

# BOSSIER CHIROPRACTIC CENTER

**ABOUT YOU: (please print)**

Today's date \_\_\_\_\_

Name: \_\_\_\_\_  Male  Female

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other Phone \_\_\_\_\_

Employer: \_\_\_\_\_ How Long: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed  Separated

Referred by:  Phone Book  Friend or Relative  Other

## ABOUT YOUR SPOUSE:

Their Name: \_\_\_\_\_ Date of birth \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ SS#: \_\_\_\_\_

## IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name \_\_\_\_\_ Relation? \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

DESIRED METHOD OF PAYMENT:  Cash  Check  Credit Card

IS CONDITION DUE TO ACCIDENT OR INJURY?  Yes  No  Auto  Work  Other

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ ( over )

We invite you to discuss frankly with us any questions regarding our services. The best medical service is based on a friendly, mutual understanding between physician and patient.

Our office policy requires payment in full for all medical services rendered at the time of visit, unless other arrangements have been made with the Office Manager. If the account is not paid within 30 days of the date of service, and no financial arrangement has been made, you will be responsible for any expenses incurred in collecting your account.

I, the undersigned, a patient in this clinic, hereby authorize Dr. James A. Wiseman (and whomever may be designated as assistants) to administer such treatments as are necessary. Also, authorization is hereby granted to release to the responsible Insurance Company, my attorney, or my employer any information deemed necessary for the filing and/or the completion of my insurance or other claims. If insurance is used for credit, I will assume full responsibility for all charges not covered by my insurance company. For credit to continue, payment must be made when billed or requested.

I hereby authorize payment of medical benefits directly to physician of benefits due me for services rendered. I also authorize Dr. James A. Wiseman to obtain legal counsel to initiate legal proceedings against my insurance company, in the event of failure to honor this assignment of benefits or failure to pay, those proceedings to include penalties, attorney's fees and court costs.

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION:** I hereby authorize and direct any physician, hospital, medical attendant, nurse, technician, or others, to furnish to Dr. James A. Wiseman records and/or x-rays pertinent to my condition. A copy of this authorization shall have the same force and effect as the original.

Date \_\_\_\_\_ Signed X \_\_\_\_\_

Witness \_\_\_\_\_ or \_\_\_\_\_  
(parent or legal guardian, if minor)

I ALSO AUTHORIZE DR. WISEMAN TO RELEASE INFORMATION ABOUT MY CONDITION TO ANY OF MY OTHER PHYSICIAN'S AS HE DEEMS NECESSARY.