COLLYARD Chiropractic

PATIENT INFORMATION

Today's Date:_____

Name: _____ Date of Birth:_____

Address:_____

City/State/Zip:_____

Telephone: (H) _____

Alternate Phone (work/cell):_____

Email Address: _____

Which form of communication do you prefer: **Phone or Email**

Employer:_____ Occupation:_____

Please list name and phone number for emergency contact:

_____ _____

How did you hear about our office?

Yellow Pages **Website/Internet** **Newspaper**

Referred By:_____ **Other:_____**

Privacy Policy:

As of April 13, 2003 our practice is required by law to maintain the privacy of your Health Information and provide you with this Privacy Notice. State law may require our practice to grant greater access/restrictions on the use of your Health Information then required by federal law. We are required to abide by the terms of this Privacy Notice. We reserve the right to change the terms of this Notice and to make new provisions effective for all your Health Information. We will distribute any revised Privacy Notice to you prior to implementation. We will not retaliate against you for filing a complaint.

By Signing below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

_____

Signature **Date**