



**CROSS**  
**SPINE & DISC**  
NON-SURGICAL SOLUTIONS

**PATIENT PERSONAL INFORMATION**

REFERRED BY: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

First

Middle Initial

Last

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_\_) \_\_\_\_\_ WORK: (\_\_\_\_\_) \_\_\_\_\_

Preferred Contact Number (Circle one): Home/Work/Cell Would you prefer appointment reminders via text? Yes or No

If Text, what cell phone carrier do you have (circle one)? AT&T Verizon T-Mobile Other: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

SOC SEC#: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ Gender: Male Female

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE#: (\_\_\_\_\_) \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION/NAME OF INSURED** (IF SAME AS ABOVE, WRITE SAME AS ABOVE)

NAME: \_\_\_\_\_

First

Middle Initial

Last

ADDRESS: \_\_\_\_\_ APT#: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_\_) \_\_\_\_\_ WORK: (\_\_\_\_\_) \_\_\_\_\_

SOC SEC#: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ Gender: Male Female

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

**CONSENT TO TREAT**

I hereby authorize consent for **Cross Chiropractic Center/Cross Spine and Disc** (Clinic) to provide medical care and treatment.

PRINT: \_\_\_\_\_ SIGN: \_\_\_\_\_ DATE: \_\_\_\_\_

Patient

Patient

PRINT: \_\_\_\_\_ SIGN: \_\_\_\_\_ DATE: \_\_\_\_\_

Legal Guardian

Legal Guardian

**AUTHORIZATION & RELEASE**

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners.

- I authorized and request my insurance company to pay directly to **Cross Chiropractic Center/Cross Spine and Disc** (clinic), insurance benefits otherwise payable to me.

- I understand that my insurance carrier may pay less than the actual bill for medical services/supplies rendered. I agree to be responsible for payment on all medical services/supplies rendered on my behalf or my dependents

PRINT: \_\_\_\_\_ SIGN: \_\_\_\_\_ DATE: \_\_\_\_\_

Patient

Patient

PRINT: \_\_\_\_\_ SIGN: \_\_\_\_\_ DATE: \_\_\_\_\_

Legal Guardian

Legal Guardian