**Shepherd Chiropractic**

# PATIENT INTAKE FORM

## PERSONAL INFORMATION

Name: _____ Date: _____
FIRST MIDDLE INITIAL LAST

Address: _____ City: _____

State: _____ ZIP _____ Phone: _____

Email: _____ Date of Birth: _____

Social Security Number: _____

Gender:
◯ Male ◯ Female ◯ Other ◯ Choose Not to Disclose Preferred Pronoun: _____

Marital Status:
◯ Single ◯ Separated/Divorced ◯ Living with Significant Other
◯ Married/Domestic Partner ◯ Widowed

What is your race? (Defined by the federal government; please check one):
◯ Asian or Pacific Islander ◯ American Indian or Alaskan Native
◯ Hispanic ◯ White
◯ Black/African American ◯ Other_____

## UNDER AGE 18?

Name of Parent/Guardian: _____ Phone: _____

Address: _____ Work Phone: _____

City: _____ State: _____ ZIP: _____

## EMPLOYMENT INFORMATION

Name of Employer: _____

Address: _____ City: _____

State: _____ ZIP: _____ Work Phone: _____

Nature of Your Work: _____

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# PATIENT ACKNOWLEDGEMENT FORM

PLEASE READ THOUROUGHLY, INITIAL YOUR ACKNOWLEDGEMENT, THEN SIGN AND PRINT YOUR NAME AND DATE.

## ASSIGNMENT OF BENEFITS

I assign all benefits payable to me for my care with Dr. Robert Shepherd. I understand that he will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this original is considered as valid as the original. _____ (**please initial**)

## GUARANTEE OF PAYMENT

I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. _____ (**please initial**)

## CANCELATION POLICY

To maintain the excellence in customer service, we request a 24-hour cancellation notification for our services. I understand that I am to notify Dr. Shepherd of a cancellation within 24 hours prior to my appointment.
_____ (**please initial**)

## MEDICARE

◯ I am not currently enrolled in Medicare
◯ I am currently enrolled in Medicare

## AUTO/WORKER'S COMPENSATION

◯ No, I do NOT have an open Auto or Worker's Compensation claim
◯ Yes, I DO have an open Auto or Worker's Compensation claim

## CONSENT FOR TREATEMENT

I, the undersigned, a patient of this clinic hereby authorize Dr. Robert Shepherd (and whomever he designates as his assistants) to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that chiropractic care, as with any health intervention, has inherent risks. These risks, though rare, could occur, ranging from a minor aggravation of current symptoms to serious conditions such as cerebral vascular accident or death. I am signing this form being fully informed by the doctor of the risks and benefits of care and the risks and benefits of not having the recommended treatment.

This authorization will remain on file and will remain in effect unless I notify you in writing of any changes.

Patient Signature: _____ Date: _____

## CONSENT FOR TREATEMENT OF A MINOR

I hereby authorize Dr. Robert Shepherd and whomever he designates as his assistant(s) to administer chiropractic care as they deem necessary to my _____. (Relationship)

Parent/Guardian Signature: _____ Date: _____

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