Chiropractor | Spinal Decompression Centre

Dr Arnie Glatter

10425 Kennedy Road North
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Tel (905) 840 1330 | Fax (905) 840 1331

CONFIDENTIAL PATIENT INFORMATION

Name: _____

Address: _____

City: _____ **Postal Code:** _____

Phone: home _____ **business:** _____

cell: _____ **email:** _____

Birthday: Month: _____ **Day:** _____ **Year:** _____ Gender: M / F

Marital Satus: M / D / W / S **Do you have an MRI? Y / N**

Children : # _____ **Spouse:** _____

Employer: _____ **Address:** _____

Referred by: Patient?: _____**Ad** _____ **Doctor?** _____**Internet?** _____

Is a this motor vehicle accident case? Y/ N

FAMILY DOCTOR: _____ **Phone Number:** _____

Address:_____

I understand and agree that health and accident insurance policies are an arrangement between myself and my insurance carriers. Furthermore, I understand that this chiropractic clinic will prepare any necessary forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. **I also understand that if I suspend or terminate treatments, all outstanding balances will be immediately paid in full.**

_____ _____

Signature **Date**

PLEASE SIGN, DATE ALL FORMS.
PLEASE ANSWER ALL QUESTIONS ON ALL FORMS.

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