ABC Wellness & Rehab
Patient Information Sheet

(Please Print)

Patient Name: ____ Male_____ Female_____
First Last Middle Initial (check one)

Home Address: ____ Home Phone: (   ) __________________

City: _____________________ State: ___________ Zip: ________ Work Phone: (   ) __________________

Date Of Birth: _______________ Age: _______ Social Security #: ____________________________

Marital Status: M_____ S_____ D_____ W_____ Email Address: ________________________

Occupation: __________________________________ Employer: ____________________________

Who referred you to this office?____

Did you have an accident?: YES _____ NO _____ If YES, what date did it happen?: ______________

Was the accident: Auto ______ Work ______ Other ______, Explain: ____________________

If this is a result of an accident, do you have an attorney? _____ If yes, Name/Address/Phone:

____

Who is responsible for the bills? ____

Insurance Company	Phone
Address	Policy #
City/State/Zip	Group #
Insured's Name	Date Of Birth _____/_____/_____
Relationship to Patient	
Insured's Employer	Phone

Assignment of Benefits/Release Of Information:

I authorize payment of insurance benefits directly to ABC Wellness & Rehab. I authorize the doctor to release all information necessary to secure payment of benefits. I authorize ABC Wellness & Rehab to obtain records from any other source or physician necessary for the course of my treatment. I consent to receive treatment by ABC Wellness & Rehab/James J. Nabzdyk, DC. The nature and purpose of the treatment, possible alternatives, and risks involved have been explained to me and I understand that there is no guarantee as to the results that may be obtained. I agree to be financially responsible for all charges incurred at ABC Wellness & Rehab including my insurance deductible, co-payment, and services not covered by my insurance company nor paid in full through any settlement or court case. Any remaining balance I agree to pay in full per the office policies of ABC Wellness & Rehab.

____ ______________________________

PATIENT SIGNATURE DATE