**CONFIDENTIAL PATIENT INFORMATION**

Dr. Wade Whittier
15 S. Dryden Place
Arlington Heights Illinois 60004
www.dpchiropractic.com
Dr. Michael J. Bagby
phone (847) 299-3440

Name _____Email Address_____ _____
Address _____City_____Zip Code _____
Home Phone _____ Cell Phone _____ Work Phone _____
Age _____ Birth Date _____ Marital M S W D How many children? _____
Occupation _____ Employer _____
Name of Wife or Husband _____Occupation_____
Employer _____ Phone _____
Emergency Contact _____Phone_____
Referred by: _____
Date of Last Exam Medical _____Chiropractic _____
What operations have you had? When?_____
_____
_____
Purpose of This Appointment _____
Other Doctors Seen For This Condition_____
Is Your Illness/Injury Work Related? Yes ____ No ____ Auto Accident? Yes _____ No _____
Has a physician treated you for any health condition in the last year? Yes _____ No _____
Describe:_____
What Medications or supplements are you taking?_____
_____
_____
Remarks and additional information _____
_____

PAYMENT IS EXPECTED AT TIME OF VISIT
Name of person responsible for payment _____
Are you insured? Yes _____ No _____ Company_____
Policy Holder _____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNDERSTAND THAT THE WELLNESS GROUP WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO THE WELLNESS GROUP 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 AND AGREE THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED TO ME WILL BE IMMEDIATELY DUE AND PAYABLE. A CHARGE WILL BE MADE FOR PREPARATION OF ADDITIONAL INSURANCE FORMS.

Patient Signature _____ SS# _____Date _____

Guardian or Spouse's Sig. Authorizing Care _____ Date _____