ID #: _____

Eckert Wellness Center

Case History • Patient Information

Clark Eckert, DC • Florence Harris, FNP-BC

Date: _____ Name: _____

Home Phone: _____ Cell Phone: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Birth Date: _____ Age: _____

Gender: _____ Marital Status: _____ Occupation: _____

Employer: _____ Office Phone: _____

In case of emergency, whom should we contact? _____

Relationship: _____ Phone: _____

How did you hear about our office? _____

Family Medical Doctor: _____ Phone: _____

When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

Name of Primary Insurance Company: _____

Subscriber Name: _____ Date of Birth: _____

Name of Secondary Insurance Company: _____

Subscriber Name: _____ Date of Birth: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. The office requires a 72-hour notice to gather your medical records after you request your patient file.

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____