

Chiro solutions, PC

“Natural Solutions for Life”

ChiroSolutions, P.C. – 310 S. County Farm Rd – Unit F
Wheaton, Illinois 60187 – Office (630) 784-8500 / Fax (630) 784-0885
Email:ChiroSolutions1@gmail.com

General Patient Information

Date: ____/____/____

Cell: (____) _____ Home: (____) _____ Work: (____) _____

Preferred Contact Number? Cell Home Work

May we leave a detailed message at the number above? Yes No

Name _____ SSN _____

Address _____ Email _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate ____/____/____

Married Widowed Single Minor Separated Divorced Partnered

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Phone (____) _____

Who may we thank for referring you / How did you hear about us? _____

Emergency Contact _____ Phone (____) _____

Relationship to Patient _____

Preferred Payment Option Insurance Medicare Cash

Assignment and Release

I certify that I, and/or my dependent(s), have insurance with _____ and assign directly to Dr. Robert Sierszulski all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company/Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

Signature of Patient, Parent, Guardian, or Personal Representative

____/____/____
Date

Please print name of Patient, Parent, Guardian, or Personal Representative

____/____/____
Date