Welcome to Desert Cities Chiropractic Date:_____

Name:_____ DOB:_____ Age:_____ Primary Language:_____

Address:_____Apt#____City:_____State:____Zip:_____ Social Sec.#:_____-_____-_____

Home Phone:_____ Cell Phone:_____ Email:_____

Sex: ☐M ☐F Status:☐Single, ☐Married, ☐Divorced, ☐Widowed Drivers License #_____

Your Employer:_____ Address:_____ Occupation:_____

Spouse's Name:_____ DOB:_____ Spouse's Employer:_____

In case of an emergency please notify:_____Phone:_____

Please Let Us Know Who Referred You- ☐Facebook ☐Groupon ☐Google ☐Verizon Yellow Pages ☐Yellow Book ☐Local Pages ☐Friend ☐Current Patient ☐Doctor ☐Yelp Other_____

INSURANCE INFORMATION

Name of Insured:_____ ID #:_____Relationship to Patient:_____

Insurance Company:_____ Phone #_____ Group #:_____

ASSIGNMENT & RELEASE OF LIABILITY

I, the undersigned, certify that I, and/or my dependent(s), have insurance coverage with _____Insurance and assign directly to Angelopoulos Chiropractic Prof. Corp./Dr. Angelopoulos 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 and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and **I agree to notify this office immediately whenever I have changes in my health condition or health plan coverage in the future.**

X_____ _____ **X**_____

Signature of Patient, Parent, Guardian or Personal Representative | Print Name and Relationship to patient | Date

CONSENT TO CHIROPRACTIC ADJUSTMENTS AND TREATMENT

I understand that Desert Cities Chiropractic is a division of Angelopoulos Chiropractic Prof. Corp. and is owned and operated by Dr. Athanasia Angelopoulos and Dr. Christopher Angelopoulos.

I acknowledge that during the course of my care I (or the person named below for whom I am legally responsible) may receive chiropractic adjustments and other chiropractic procedures, including various modes of physiotherapy, massage and diagnostic x-rays by Dr. Athanasia Angelopoulos, Dr. Christopher Angelopoulos and/or I understand that, as the practice of medicine, in the practice of other clinical therapies there are some risks to treatment. I understand that if I receive chiropractic treatments the most common risks are temporary aggravation of my condition/soreness or bruising. Rarer risks include, but are not limited to, fractures, strokes, dislocation, sprains, burns and aggravation of disc injuries.

I do not expect the practitioner to be able to anticipate and explain all risks and complications, and I wish to rely on him or her to exercise judgment during the course of the procedure which he or she feels at the time, based on the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. By signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

X_____ _____ **X**_____

Signature of Patient, Parent, Guardian or Personal Representative | Print Name and Relationship to patient | Date

NOTICE OF PRIVACY PRACTICES

I have read the Notice of Privacy Practices that was provided to me. I understand that I have the right to a paper copy of this policy at any time upon request. If I have any questions, I may contact Dr. Athanasia Angelopoulos at 760-952-3300.

X_____ _____ **X**_____

Signature of Patient, Parent, Guardian or Personal Representative | Print Name and Relationship to patient | Date

STATEMENT OF NO ACCIDENT OR INJURY

I certify that my condition is not the result of an auto accident or work related injury.

X_____ _____ **X**_____

Signature of Patient, Parent, Guardian or Personal Representative | Print Name and Relationship to patient | Date