Staci Talan, D.C., I.D.E., Q.M.E.
Chiropractor * Industrial Disability Examiner (IDE) * Qualified Medical Examiner (QME)
39809 Paseo Padre Parkway, Fremont, CA 94538 * TEL: 510-657-1234 * FAX: 510-657-1233

CONFIDENTIAL PATIENT INTAKE FORM

PLEASE LET US KNOW HOW YOU WERE REFERRED TO OUR OFFICE: _____

First Name: _____ MI: _____ Last Name:_____
Street: _____ Apt. #: _____
City: _____ State: _____ Zip code: _____
Home Phone: _____ Cell Phone: _____Work Phone: ____ _____
Email: _____ Emergency Contact: _____Phone:_____
Social Security #: _____ Drivers License #: _____
Date of Birth: _____ Marital Status: S M W D Spouse: _____
Occupation: _____ Business/Employer Name: _____
Employer's Address:_____

INSURANCE INFORMATION

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policy holder? Y N If no, who is the policy holder: Spouse Parent Employer Other
Policy Holder's First Name: _____ MI: _____ Last Name:_____
Policy Holder's Date of Birth: _____ Policy Holder's Member ID:_____
Name of Insurance _____ Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's First Name: _____ MI: _____ Last Name: _____
Policy Holder's Date of Birth: _____ Policy Holder's Member ID#: _____
Name of Insurance _____ Policy Holder's Employer: _____

IF YOU WERE INVOLVED IN AN ACCIDENT, PLEASE COMPLETE THE FOLLOWING:

Is the injury a result of an automobile accident? Y_____ N_____

Date of Accident: _____/_____/_____

Did the Injury Occur at Work? Y_____ N_____ Date of Injury _____/_____/_____

Is the injury due to another type of accident? Please Describe: _____

ASSIGNMENT & RELEASE

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized is to be paid directly to Dr. Staci Talan, D.C., Q.M.E for services rendered and will be credited to my account upon 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 that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature: _____

Consent of Professional Services and Release of Information

I hereby authorize and release Dr. Staci Talan, D.C., Q.M.E. and whomever she may designate as her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care or any clinic services that she deems necessary in my case; I furthermore authorize her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

Patient's/Parent's/Guardian's Signature: _____