PATIENT INTAKE FORM

Patient Name: _____ Date of Birth: _____

Full Address: _____

House Phone #: _____ Mobile #: _____ Work #: _____

Employer: _____ Occupation: _____

Married: __ Single: __ Other: __ Male __ Female: __Social Security#:_____

Emergency Contact Person: _____

Relationship: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance: _____ Member ID: _____

Secondary Insurance _____ Member ID: _____

XRAY

FEMALE

I give Dr. Eugene Kitts, DC, ND permission to do X-RAY on my body and verify that I am NOT pregnant.

Last Date of menstrual cycle: _____

MALE

I give Dr. Eugene Kitts, DC, ND permission to do X-RAY on my body.

I certify that all the information I have provided above is true and correct.

_____ _____

Patient Name (PRINT) Date

_____

Patient Signature

PATIENT ACKNOWLEDGEMENT

I hereby acknowledge that I have been provided with the practices' **NOTICE OF PRIVACY PRACTICES** and that I have read and fully understand the notice. I have been provided with the opportunity to ask questions about the notice and my question have been answered to my satisfaction.

Patient Name (**PRINT**): _____ Date: _____

Patient Name Signature: _____