Applied Kinesiology
Trigger Points Therapy
Exercise and Nutritional counseling

Confidential General Patient Information

Please Print

Patient's Name (last, first, MI): ________________________________Today's date_____________

Address:____

City: _______________________________ State:________ Zip_____________________________

Phone # @ Home:__________________ Cell:_________________ Work: _____________________

Date of birth:___________________ S.S.# ________________________M/F Marital status M S D W

Occupation____________________ Employer _____________________

Address:____

City: _______________________________ State:________ Zip_____________________________

Spouse's Name ____

Name of person to contact in emergency__________________________ Phone # _______________
Is your visit due to an accident? Y/N
Who referred you to this office?(Please circle one) friend, relative , Dr., attorney, ad, flyer, lecture, etc.

Name: ____

Insurance Carrier: __________________ Policy #_______________ Group # ___________________

Address:____

City: _______________________________ State:________ Zip_____________________________

Phone #:__________________ Subscriber's Name: ______________________________________

Attorney:____

Address:____

City: _______________________________ State:______ Zip________ Phone #:__________________

I understand and agree that if I have a health and/or accident insurance, these policies are an arrangement between the insurance carrier and me. Further, I understand that Dr. Lesman will prepare any necessary reports and forms to assist me in making collection from my insurance easier and that any amount authorized to be paid to Dr. Lesman will be credited to my account. However, I clearly understand and agree that all services rendered, are charged directly to me and that I am personally responsible for payment.

I give permission for future follow-up phone calls.

I hereby authorize Dr. Erwin Lesman to examine and treat my condition as he deems appropriate thorough the use of Chiropractic treatments and I give authority for these procedures to be performed. It is understood and agreed the amount paid to Dr. Lesman for X-rays is for examination only, and the negatives will remain the property of this office, and will be on file.

Patient's Signature ____ **Date:**_______________

Guardian's Signature ____ **Date:**_______________