Todd B. Andrews, D.C.
1501 N. Placentia Ave.
Placentia, CA 92870
(714) 572-3834

Date_____

PLEASE PRINT

PATIENT INFORMATION

Name_____
Address_____
City_____ Zip_____
Birth Date_____ Sex M F
Home Phone #_____
Cellular Phone #_____
Social Security #_____
Driver License #_____
Marital Status_____
Email Address_____
Referred By_____

EMPLOYER INFORMATION

Occupation_____
Employer_____
Employer Address_____
City_____ Zip_____
Business Phone #_____ext._____

RESPONSIBLE PARTY INFORMATION

(if other than self)
Name_____
Relationship to Patient_____
Social Security #_____ DOB_____
Home Phone #_____
Cellular Phone #_____
Work Phone #_____
Address_____
City_____ Zip_____
Employer's Name_____
Address_____
City_____ Zip_____
Occupation_____
If patient is a child, name of other parent
_____
Address_____
City_____ Zip_____
Home Phone #_____
Work #_____

REASON FOR CONSULTATION

What are your present complaints and symptoms?
_____
_____
Is your condition a result of a: Work injury?_____
Auto accident?_____
Other_____
Date of injury or onset_____
Family Physician_____
Phone #_____

INSURANCE INFORMATION

Are you insured ? Y N
(Please present insurance card to receptionist)
Insurance Company_____
Other Insurance Company_____

EMERGENCY CONTACT

Name_____
Relationship_____
Phone #_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment of benefits be made directly to this healthcare provider and I understand that I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process this claim.

Signed_____ Date_____
(Insured Person)

CONSENT TO TREATMENT OF A MINOR

I (we) being the parent or guardian of the above patient, a minor, the age of _____, do hereby consent, authorize and request Dr. Andrews and whomever he may designate as his assistant, to administer such treatment deemed advisable, necessary or requested for this minor.

Signed_____ Date_____
(Parent or Legal Guardian)