

Ottawa Village Chiropractic, PLC
Greg Lynas, DC

PATIENT NAME: _____
FILE NO: _____

WELCOME

The doctor and staff of **Ottawa Village Chiropractic, PLC** welcome you and want to provide you with the best possible care. We will conduct a thorough history and physical examination to decide if we can assist you. If we do not believe that your condition will respond to chiropractic care, we will not accept you as a patient but will refer you to another health care provider, if appropriate.

INSURANCE

This office will process your insurance forms upon request. We will do our utmost to provide sufficient information to your carrier to obtain payment for your treatment. We have found that, in some instances, however, insurance companies will deny or reduce payment despite our best efforts to demonstrate the necessity for care. In the event that full payment is not made for any reason, you must understand that you are responsible to make payment in full.

PATIENT IDENTIFICATION

_____	Name or Nickname I prefer to be called
Name _____	in this office _____
_____	Telephone (Home) _____
Street _____	(Work) _____
_____	Ok to call there? Yes () No ()
City, State and Zip _____	_____
_____	Occupation _____
Social Security # _____	_____
Male () Female () _____	_____
_____	Date of Birth _____ Age _____
Contact in case of emergency, Name: _____	_____
_____	Telephone # _____
Name of Parent of Minor Patient (If applicable) _____	_____

ACCEPTANCE AS PATIENT

I understand and agree that the doctors of **Ottawa Village Chiropractic, PLC** have the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Date

Signature

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