

## Patient Introduction Card

Date: \_\_\_\_\_  
Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_, State \_\_\_\_\_ Zip \_\_\_\_\_ Employer \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Phone (home) \_\_\_\_\_  
Phone (business) \_\_\_\_\_ Address \_\_\_\_\_  
Sex: M/F Status: Single/ Married/ Divorced/ Wid \_\_\_\_\_  
Patient S.S. # \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Referred to this office by: \_\_\_\_\_

I may be informed by Dr. Chris Oliver that diagnostic x-rays are advisable in my case so that a complete analysis can be made of my present musculoskeletal problem or illness. I authorize Dr. Oliver to perform such radiographic examinations as necessary to diagnose and to administer whatever treatment is deemed necessary to treat my present problem or illness.

**Patient's Signature:** \_\_\_\_\_

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorized the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the party who accepts assignment below.

**Patient's Signature:** \_\_\_\_\_

INSURED'S OR AUTHORIZED SIGNATURE. I authorized payment of medical benefits to Dr. Chris Oliver of Complete Health Chiropractic and Acupuncture for services performed.

**Patient's Signature:** \_\_\_\_\_

I understand and agree that, regardless of my insurance, I am responsible for the balance on my account for the professional services rendered. I also understand that if at any time default occurs on my account I will be not only responsible for the total balance due but also any reasonable attorney fees, address searches as well as a 1% per month interest rate. I certify the information I have provided in this packet is true and correct to the best of my knowledge. I will notify you of any changes in my health status.

**Patient Signature:** \_\_\_\_\_

The best of my knowledge, I am NOT pregnant, and Dr. Oliver has my permission to x-ray me.

**Patient's Signature:** \_\_\_\_\_

I AUTHORIZE THE TREATMENT OF THIS MINOR. (If applicable)

**Parent Signature:** \_\_\_\_\_

I, \_\_\_\_\_, request the release of my x-rays and all medical records from Dr. \_\_\_\_\_. I release Dr. \_\_\_\_\_ from any and all claims from release, as I realize that these are permanent records. Please send my x-rays to:

**Complete Health Chiropractic and Acupuncture  
Dr. Chris Oliver  
208 Elden St. Herndon, VA 20170**

**Patient's Signature:** \_\_\_\_\_

Dr. Chris Oliver and staff of Complete Health Chiropractic and Acupuncture have my permission to use my name as a referral source and place it on display on the referral board.

**Patient's Signature:** \_\_\_\_\_