

Edelson Wellness Center

Steven Edelson, D.C., MSW
Chiropractic Physician

<http://tampa.chiropractor-edelson.com> (813) 831-8321
4250 Bay to Bay Blvd. Tampa, Florida 33629

Date: _____

Mr. Mrs. Ms. Dr.

Name: _____ SEX : M F (circle one)
First Middle Init. Last

Nickname preferred to be called by: _____

Address: _____

City: _____ State: _____ Zip: _____

SS Number: _____ - _____ - _____ Date of birth: _____ Age: _____

Home Phone: _____ Cell Phone _____ Work Phone: _____ Email: _____

Driver's License #: _____ State: _____

Employer: _____ Occupation: _____

Name of spouse/significant other: _____

Who referred you to our office? _____

What is your major complaint?: _____

Is condition due to: A. work injury B. auto accident C. household accident

If condition was a result of any of above, what was the date of the accident? _____

If condition *WAS NOT* related to an *AUTO* accident, please describe what happened:

PAYMENT INFORMATION:

Your insurance company: _____

Insurance address: _____

Insurance phone: (____) _____ - _____

Name of insured: _____ ID#: _____

Do you have an attorney representing you? YES NO

Name of attorney: _____ Phone Number: (____) _____ - _____

Fees are payable at the time of service, unless other arrangements have been made. Florida law requires that patient records including x-rays, be retained by the physician, but may be copied or released upon your request.

I authorize the above named doctor or clinic to furnish information concerning my present illness or injury and direct the insurer to pay, without equivocation, directly to the above named doctor or clinic, any and all benefits due them as a result of this claim. I am aware that I am personally responsible for all charges and/or balances not covered by my insurance. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

Patient's signature: _____ Date: _____

(I give my consent to treat)

Guardian/spouse's signature: _____ Date: _____

(I give my consent to treat)