PATIENT UPDATE FORM

KAISER CHIROPRACTIC, S.C.

NAME:		**DATE OF BIRTH:**	**DATE:**
PHYSICAL ADDRESS (NEEDED IF YOU HAVE A P.O. BOX):		**CITY:**	**STATE/ZIP CODE:**
MAILING ADDRESS:		**CITY:**	**STATE/ZIP CODE:**
HOME PHONE:	**CELL PHONE:**	**EMAIL ADDRESS:**	

☐ **YES** ☐ **NO** I WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS EITHER BY TEXT MESSAGE **(CELL PHONE CARRIER_____)** OR BY E-MAIL

EMERGENCY CONTACT INFO:
(NAME, PHONE # & RELATIONSHIP)

LIST ALL MEDICATIONS YOU'RE TAKING (INCLUDE OVER THE COUNTER MEDS.):
ARE ANY PRESCRIPTIONS FOR: HIGH BLOOD PRESSURE? ☐ YES ☐ NO HIGH CHOLESTEROL? ☐ YES ☐ NO

MEDICATION ALLERGIES:

DO YOU HAVE INSURANCE SUPPORT?
☐ YES I DO AND I WILL PRESENT MY INSURANCE CARD TO BE COPIED
☐ NO I DO NOT HAVE INSURANCE SUPPORT

- I hereby give permission to Dr. Kaiser & Kaiser Chiropractic, S.C. to administer treatment and perform such general procedures, as deemed necessary in the diagnosis and/or treatment of my condition.
- I hereby authorize and direct my insurance benefits to be paid directly to the doctor.
- I acknowledge that I am always responsible for all care left unpaid by my insurance regardless of the reason. This includes charges that are outside of the network benefits/policy limits, care that is termed not medically necessary, maintenance/routine care, ineligible or non-covered services.
- I understand that delinquent accounts accumulate at 12% interest annually.

☐ **I do agree to these terms**

Patient Signature:_____ Date: _____

790 Gardner Street • Lake Geneva, WI 53147 • 262.248.4001 • 262.248.4069 fax