



Dr. William M. Byrnes
Director

Privacy Policy Acknowledgement

Name: _____

Patient Acknowledgement:

I acknowledge that I have read/received a copy of South Shore Family Chiropractic's Notice of Privacy Practices in accordance with federal regulations dictated by the Health Insurance Portability and Accountability Act.(HIPAA).

Signature of Patient Print Name Date

Signature of Parent/Guardian Print Name Date



Chiropractic

South Shore Family

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Director

We offer a unique service to individuals and families. We are happy you have chosen to use our services. We will make every effort to make your experience supportive, informative and healing. Please complete the following:

Name _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Date of Birth _____ Age _____ Marital Status S M Loved One

Employment Status: Full-Time Part-Time Student Retired Unemployed

Occupation _____ Employer _____

Business Address _____

Significant Other's Name _____ Significant Other's Occupation _____

Name & Ages of Children _____

How did you hear about us? _____

Name & Relation of Person Who Referred You _____

Are you planning on using some type of insurance or third party reimbursement? Y N

Person Responsible for Account _____

Signature _____ Today's Date _____

The goal of chiropractic care is to keep the body free from vertebral subluxations. Today, we will explain to you exactly what vertebral subluxations are and evaluate your spine.

Continued on reverse side →

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No. Weymouth, MA 02191

e-mail: ssfamilychiro@comcast.net
web: www.ssfamily.com

(781) 335-7671
Fax (781) 335-7856

Reason for Consulting our office _____

Previous chiropractic care ___ Y ___ N With Whom _____

How Long _____ Date of Last Visit _____

Why did you stop care _____

Circle any of the following symptoms that you have experienced in the past 6 months:

Headaches	Neck Pain	Muscle Spasms	Nervousness
Migraine/Tension	Tension Across	Irritability	Menstrual Problems
Headaches	Shoulders	Dizziness	Fatigued, Tired
Shoulder Pain	Leg/Foot Pain	Allergies	Difficulty Sleeping
Arm/Hand Pain	Tingling in Legs/Feet	Depression	Difficulty Bending
Tingling in Arms/Hands	Knee Pain	Digestive Problems	Physical Weakness
High Blood Pressure	Mid-Back Pain	Weight Trouble	Asthma
Jaw Pain (TMJ)	Low Back Pain	Ringling in ears	Several Flus / Colds
	Fibromyalgia		

Other Health Problems: _____

How committed are you to your HEALTH?

1. Not at all 2. Somewhat 3. My health is very important to me!

NEW PATIENT REGISTRATION

South Shore Family Chiropractic

Please print clearly to help avoid billing errors

Patient Last Name _____ First _____ MI _____

Mailing Address _____ Email _____

City _____ State _____ Zip _____

Home Telephone _____ Cell Number _____ Work Telephone _____

Date of Birth _____ Age _____ Social Security # _____

Insurance Company _____ Insurance ID # _____ Co-Pay/Deductible _____ # Visits PCY _____

Marital Status: Single Married Other

Sex: Male Female

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired

GUARANTOR NAME & ADDRESS - Person to Bill if Other Than Patient _____

Assignment and Release: I hereby authorize and direct my insurance benefits to be paid directly to South Shore Family Chiropractic and understand I am financially responsible for any and all non-covered services provided by South Shore Family Chiropractic.

Signature: _____ Date: _____