APPLICATION FOR CARE FORM

Last Name: _____ First Name: _____ Middle Initial: _____

Home Phone: _____Work Phone: _____

Cell Phone: _____

Email_____

Street Address and Number: _____

Mailing Address (if Different) _____

City, State and Zip Code: _____

Date of Birth: _____ Social Security #: _____

Employer_____

Employer Address_____

Reason for this visit: _____

Result of fall or particular incident: _____

Pregnant: _____Yes _____ No

CONSENT TO TREAT

I hereby authorize Dr. Saracina to examine me, and to release my records to anyone I designate. I further authorize treatments deemed necessary by the findings and wish all my chiropractic records to be held in strict secret confidence and not to be given to anyone without my written consent. I clearly understand that I am totally responsible for payment.

By signing your name below, you certify the accuracy of your medical and;/or accident history and further certify that you present to Dr. Saracina/Atlantic Chiropractic and Rehab for evaluation and treatment of a health related condition and for no other purpose.

_____ _____

Signature of patient, or Guardian Authorizing care Date