EASTSIDE CHIROPRACTIC, P.C.
1011 WOODRIDGE LANE, BLDG 301
WATKINSVILLE, GEORGIA 30677
Ph: 706.310.1121 Fax: 706.310.1165

DR. BRYAN HOOPER
DR. CHRIS LAMMERT
ASHLEY MCDONALD, LMT

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help. Please print.

Name ____ Date______________________
Address____ Date of Birth __________________
City ___________________________________ State _________ Zip____________ Sex at Birth: ☐ Male ☐ Female
Cell (________) _______________________ Carrier _______________Home (________)_____________________
I prefer to receive calls at: ☐ home ☐ cell Email: ____
I consent to receive reminders (*please select & initial **ONE** option*): ☐ _____email ☐ _____text ☐ _____call
Patient employer/school ____
City_____________________ State________ Zip___________ Work Phone (______) _________________________
Whom may we thank for referring you to us? ____
Emergency Contact ____ Phone (_______)____________________

RESPONSIBLE PARTY

Name of person responsible for this account ____
Relationship to patient___________________________________ Phone (________)______________________
Address____
City__________________________ State________ Zip____________ Employer___________________________

****PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD FOR VERIFICATION****

Certification and Assignment

I certify that I, and/or my dependent(s), have insurance with ____ and assign directly to the Practice, Eastside Chiropractic, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions.

Eastside Chiropractic may use my healthcare information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or at the termination of the benefits from the company stated above.

____ ____________________________
Signature of patient, guardian, or personal representative Date

____ ____________________________
Print name of patient, parent, guardian, or personal representative Date