

CUNNINGHAM CHIROPRACTIC, P.C.
George Cunningham, D.C.
Callan Carnahan, D.C.
210 Old Bridge Street
East Syracuse, N.Y. 13057
REACTIVATION/ NEW PROBLEM FORM

Name: _____ D.O.B. ____/____/____ Male Female
 Married Single Divorced Widowed SSN: ____/____/____ (REQUIRED)

Address: _____ City: _____ State: _____ Zip: _____

Phone#:(____)-_____ Cell: (____)-_____ Work: (____)-_____

Employer: _____ Address: _____ City: _____ State: _____

Zip: _____ Occupation: _____ Are you working now? Yes No Full time Part time

Statements Emailed? Yes No Email: _____

Appointment Reminders? Yes No Cell Phone Carrier: _____

What is your main Complaint? _____

Is this a new injury/condition? Yes No...If yes please describe _____

Are there any changes in your health history? Yes No If yes, please describe _____

Would you like Cunningham Chiropractic's office to send notes to another provider: Yes No if yes, Name & address of Doctor: _____

Consent to Communicate Information to an Authorized Person

This allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with Cunningham Chiropractic, P.C. This form when signed allows Cunningham Chiropractic, P.C. to speak to this authorized person about your personal information concerning insurance benefits, payments, treatment or any other health care information regarding your care. I _____ (your name) hereby give my consent for Cunningham Chiropractic, P.C. to communicate personal information on my behalf to the authorized person(s) named below. I may revoke this authorization at any time in writing to Cunningham Chiropractic, P.C. 210 Old Bridge Street East Syracuse NY 13057. This authorization allows Cunningham Chiropractic, P.C. to speak with the authorized person(s) regarding: Treatment, insurance benefits, copays or any other aspects regarding care.

Signature: _____ Date: _____

Person(s) Authorized to speak with Cunningham Chiropractic, P.C.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Insurance Co Name: _____ Member ID/Claim# _____

Who is the subscriber? _____ Their DOB: ____/____/____ Group#: _____

INSURANCE POLICY

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Cunningham Chiropractic, P.C. all insurance benefits, if any otherwise payable to me for services rendered. I know that I am financially responsible for all charges including durable medical equipment and supplements whether or not paid by insurance. If the account goes to collections, I understand that I am responsible for any and all collection fees. I hereby authorize the doctor to release all information necessary to secure the benefits. I authorize the use of this signature on all insurance submissions. I also understand a quote of benefits does not guarantee payment. Payments of insurance benefits are subject to terms, limitations, and the plan exclusions at the time services are rendered.

Name:

Signature:

Date:
(PLEASE FILL OUT NEXT PAGE)

