Carlisle Chiropractic Clinic – North
537 West Sugar Creek Road, Suite 101
Charlotte, North Carolina 28213

Dr. Henry Rice
Dr. Ferzaan Ali

Date of Accident/Injury:
_____/_____/_____

New Patient Information
(Please PRINT Clearly)

Today's Date: _____/_____/_____ Chart #: _____

Name: _____
First Middle Last Maiden

Address: _____ Apartment #:_____

City: _____ State _____ ZIP _____ Driver's License #: _____

Social Security #: _____ E-Mail Address: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

DOB: _____/_____/_____ Age: _____ Gender: Male___ Female___ Marital Status: _____

Employer: _____ Work Phone: (_____) _____-_____

Business Address: _____

Name of Spouse(parent): _____ Spouse's SSN: _____

Spouse's Employer: _____ Address: _____

Spouse's Work Phone: (_____) _____-_____ Spouse's DOB: _____/_____/_____

Previous Chiropractic Care? Yes ☐ No ☐ Doctor's Name: _____

Health Insurance Company: _____(please provide a copy of your insurance card)

Major Complaint: _____

Nearest Friend or relative that can be contacted in case of an emergency: _____

Relationship: _____ Phone #: (_____) _____-_____

It is usual and customary to pay for services as rendered unless otherwise arranged.

I do hereby authorize Carlisle Chiropractic Clinic, (Henry Rice D.C./Ferzaan A. Ali, D.C.) to furnish my Insurance Co. with a full report of physical examination, diagnosis, treatment, prognosis, etc. of myself in regard to my injury, if requested by them.

I hereby authorize and direct payment directly to said doctor such sums as may be due on owing him for chiropractic service rendered me. I understand I am directly and fully responsible to said doctor for all medical bills submitted by him for service rendered me. This agreement is made solely for said doctor's additional protection and in consideration of his awaiting payment.

I have read and agree to be bound by the terms of his assignment of benefits. I have also been advised that if my insurance company does not cooperate in protecting said doctor's interest, he will not await payment but may declare this entire balance due and payable; these assigned proceeds shall not exceed amounts due and payable to said doctor for services rendered.

Patient's Signature: _____ **Date:** _____