Real Health Chiropractic

1601 52nd Avenue, Suite 5
Moline, IL 61265

Name _____ Date of Birth____/____/_____

Social Security #_____

Street Address _____.

City _____ State _____ Zip Code _____

Cell Phone# _____Cell Carrier_____(AT&T/Verizon/Sprint)
Text Appt. Reminder Program Circle Option Yes/No

Email Address _____@_____.com
Email Appt. Reminder Program Circle Option Yes/No

Occupation/Employer _____

Primary Physician_____.

Current Medications/Dosage	**Allergies**

Patient Acknowledgement and Receipt of
Notice of Privacy Practices Pursuant to HIPAA and Consent for Use of Health Information

The undersigned does hereby acknowledge that he or she has received a copy of this office's Notice of Privacy Practices Pursuant To HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State law and Federal Law.

Patient Signature_____Date
If patient is a minor or under a guardianship order as defined by State law:

Relationship to Patient_____Initial/Date_____/_____