

HOLLSTROM & ASSOCIATES, INC
11444 SEMINOLE BLVD, LARGO, FL 33778

CENTER FOR BACK AND NECK PAIN
727 393-6100 727 393-5461 (FAX)

LEGAL

NAME: First _____ Middle Initial _____ Last _____ Nickname: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

OTHER ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORKPHONE: _____ OTHER#: _____
(Cell/Beeper)

EMPLOYER: _____ OCCUPATION _____

YOUR SOCIAL SECURITY #: _____ YOUR DATE OF BIRTH: _____

WHO IS YOUR FAMILY OR PRIMARY DOCTOR? _____

EMAIL ADDRESS: _____

SPOUSE NAME: _____ SPOUSE CELL/WORK
NUMBER: _____

IF SPOUSE IS PRIMARY INSURED FOR YOUR INSURANCE:

SPOUSE'S DOB: _____ SPOUSE'S EMPLOYER: _____

SPOUSE / INSURED SS# _____ (Spouse's information is for insurance and identification purposes only)

EMERGENCY CONTACT:(If not spouse listed above)

NAME: _____ RELATIONSHIP: _____ PHONE#: _____

HOW DID YOU LEARN ABOUT OUR PRACTICE? _____

IF CARE IS RELATED TO AN INJURY, DO YOU HAVE AN ATTORNEY? YES _____ NO _____

NAME OF ATTORNEY _____

WHO IS RESPONSIBLE FOR PAYMENT? _____ SELF _____ SPOUSE _____ PARENT _____ OTHER _____

(Please give your insurance card to the receptionist with this form.) Work Comp authorization must be obtained prior to treatment. If your PCP must authorize care, it must be done prior to treatment (Most Chiropractic is Open Access).

ARE YOU PREGNANT? YES _____ NO _____

By my signature, I attest that the above information is accurate to the best of my knowledge.

Signature: _____ Date: _____

CONSENT TO TREAT AND EXAMINE A MINOR: I authorize Hollstrom & Associates, Inc physicians and whomever they designate as assistants to examine, x-ray, and administer appropriate care as they deem necessary to my child.

Signature of Parent or Guardian: _____

Printed Name: _____

Phone Number where you can be reached during the day: _____