Dr. Amina Ahmad
AA Spine & Rehab Clinic

6767 W. Greenfield Ave., Suite 201 (2nd Floor)
West Allis, WI 53214

Patient Information

_____ _____ _____
First Name **Middle Name** **Last Name**

_____ _____ _____ _____ _____
Address **Apt #** **City** **State** **Zip Code**

_____ _____ _____
Home Telephone Number **Work Telephone Number** **Work Fax Number**

_____ _____ _____ _____ _____ _____
Date of Birth **Age** **Social Security Number** **Date of Injury** **Height** **Weight**

Marital Status: Single_____ Married_____ Divorced_____ Separated_____ Widowed_____

Gender: Male_____ Female_____ Other _____

Race/Ethnic Background: Hispanic_____ Caucasian_____ Native/Indian_____ African American_____ Asian_____

You live with: Live Alone_____ With Spouse_____ With Parents_____ With Children_____ # of Children _____

Cell Phone Number: (_____) _____-_____ E-Mail Address: _____

Health Insurance OR Auto Insurance OR Worker's Compensation Insurance Information

_____ _____
Name of Company **Claim # OR Policy #**

_____ _____ _____ _____ _____
Address **Apt #** **City** **State** **Zip Code**

_____ _____ _____
Office Number **Fax Number** **Name of Adjuster**

Is your illness of injury related to any of the following?

Work Injury_____ Accident (slip & fall)_____ Auto Accident (Car Accident)_____ No Injury_____

Attorney Name (if any):_____ Cell Phone Number:_____

Attorney E-Mail: _____

Signatures Are Required on the Second Page

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Consent to Treatment & Release of Information

I voluntarily consent to receive medical and health care services from Dr. Amina Ahamd and/or AA Spine & Rehab Clinic, that may include diagnosis procedures examinations and treatment. I authorize the release of any medical information necessary to process this claim.

Financial Responsibility and Assignment of Benefits

I authorize Dr. Amina Ahmad and/or AA Spine & Rehab Clinic to bill and collect for medical and health care services not covered by my health insurance company, car insurance and third-party insurance companies.

I also authorize Dr. Amina Ahmad and AA Spine & Rehab Clinic to receive direct payment to the doctor/clinic for health insurance and/or MED-PAY coverage of my policy.

I certify that I have read this form and understand its contents.

_____ _____

Signature of Patient OR Authorized Legal Person **Date**

CONSENT TO TREATMENT OF MINOR

(I)(We), the undersigned, parent(s)/person having legal custody/legal guardianship of

_____, a minor, do hereby authorize _____
(Name of Minor) (Name of Agent)

as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above-described agent(s) to give specific consent to any and/or all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until _____, 20_____, unless sooner
(Month and Day) (Year)

revoked in writing delivered to the agent(s) noted above.

Date: _____

Signature: _____
(parent/legal guardian/person having legal custody) (circle relationship)

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Signature: _____
(parent)