

Dr. Richard E. Picard

WELCOME TO OUR OFFICE

Name: _____ Date: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ SS#: _____

Age: _____ Birth Date: _____ Occupation: _____

Marital Status (circle one) M S D W Spouse Name: _____

Cell Phone: _____ E-mail: _____

Employed By: _____ Business Phone: _____

Business Address: _____

Health Insurance: _____ Policy #: _____

Insured Name: _____ Birth Date: _____

Insured's Employer: _____

Medical Doctor: _____ City/Phone: _____

In case of emergency, whom should be notified? _____ Phone: _____

How did you hear about us?

Doctor Phone book Sign Friend Internet Other source: _____

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services.

I hereby give my permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and/or treatment of my condition.

I understand that just as there is a risk in all medical procedures, although rare, cervical spine manipulation can cause vertebral artery injury (stroke) in 1/500,000 cases.

By signing below I have read and agree to the above statements.

Print Name: _____

Signature: _____ Date: _____