Spennetta Family Care Chiropractic
6810 Watts Road • Madison, WI 53719 • (608) 273-Back (2225)
Where our patients are treated like family!
Dr. James A. Spennetta, D.C.

CONSULTATION ADMITTANCE FORM

Date	
Patient Name	Home Phone
Address	City/State/Zip
Age Birth Date	Sex (Circle) MALE or FEMALE
Marital Status (Circle) M S W D	No. of Children
Social Security No.	Occupation
Employer	Business Phone
Employer's Address	City/State/Zip
Spouse's Name	Occupation
Employer	Business Phone
Who may we thank for referring you?	
Who is responsible for this account?	Relationship
Payment is expected at time of visit. Method of payment you are using today? (Circle) CASH CHECK CREDIT CARD	

In case of an emergency, who should be notified?	Relationship
Contact Address	Contact Phone No.

Insurance Co.	Effective Date
Policy No.	Group No.
Subscriber Name	Birth Date SS#
Subscriber Address	City/State/Zip
Relationship to Insured (Circle) SELF SPOUSE CHILD OTHER	

Have you had Chiropractic Treatment before? (Circle) YES or NO	
Where? When?	X-rays? (Circle) YES or NO

PATIENT AGREEMENT

I, the undersigned, assign directly to DR. SPENNETTA all medical benefits, if any, otherwise payable to me for services rendered. This office will gladly prepare medical claim forms, however, services can not be rendered on the assumption that charges will be paid by my insurance company, I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand the free consultation with the Doctor is to determine whether I will benefit from Chiropractic care, necessary examination and/or x-rays will be recommended. The examination and/or x-rays are NOT part of the free consultation. In addition, I hereby authorize the Doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature, and any copy of this authorization, on all my insurance submissions. I have fully read and understand the above.

Signature of Patient/Guardian :	Date :

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CONSULTATION ADMITTANCE FORM

Date/Fecha	
Patient Name Nombre del Paciente:	Home Phone No. Telefono de casa:
Address Direccion:	City/State/Zip Ciudad/Estado/Codigo Postal
Age/Edad: Sex/Sexo (Circle/Encierre)	Birth Date/Fecha de Nacimiento: Male/Masculino or Female/Femenino
Marital Status (Circle) M S W D Estado Marital (encierre) Casado(a) Soltero(a) Viudo(a) Divorciado(a)	No. of Children No. de Hijos:
Social Security No.: No. de Seguro Social:	Occupation: En que trabaja:
Employer: Empleador:	Business Phone: No. Telefonico del empleador:
Employer's Address Direccion de Empleador	City/State/Zip Ciudad/Estado/CodigoPostal
Spouse's Name Nombre del Conyugue:	Occupation: En que trabaja:
Employer/Empleador	Business Phone/ Tel. del Trabajo
Who may we thank for referring you? A quien le agradecemos por referirle?	
Who is responsible for this account? Quien sera responsable por la cuenta?	Relationship Relacion:
Payment is expected at time of visit. / Un Pago es requerido en esta visita.	
Method of payment you are using today? (Circle) CASH CHECK CREDIT CARD Que metodo de pago usara hoy? (encierre) Efectivo Cheque Targeta de Credito	

In case of an emergency, who should be notified?	Relationship
En caso de emergencia, a quien le notificamos?	Relacion
Contact Address Direccion de Contacto	Contact Phone No. No. Telefonico

Insurance Co./Seguro Medico	Effective Date/Efectivo
Policy No./No. de Polisa	Group No./No. de Grupo
Subscriber Name Nombre del Beneficiario Inscrito:	Birth Date SS# Fecha de Nacimiento #Seg/Soc.
Subscriber Address Direccion del Inscrito	City/State/Zip Ciud./Est./Cod.Post.
Relationship to Insured (Circle) SELF SPOUSE CHILD OTHER Relacion con el Inscrito (encierre) YO ESPOSA(o) HIJO(a) OTRO	

Have you had Chiropractic Treatment before? (Circle) YES or NO Ah recibido tratamiento con Quiropractico antes? (encierre) SI o NO		
Where? Donde?	When? Cuando?	X-rays? (Circle) YES or NO Radio-grafias? SI o No

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necessary examination and/or x-rays will be recommended. The examination and/or x-rays are NOT part of the free consultation.
In addition, I hereby authorize the Doctor to release all information necessary to secure the payment of benefits.
I authorize the use of this signature, and any copy of this authorization, on all my insurance submissions.
I have fully read and understand the above.

Acuerdo del Paciente

Yo, quien firmo, directamente asigno al Dr. SPENNETTA todos los beneficios medicos, si hay alguno, de lo contrario pagaderos a mi por los servicios recividos.
Esta oficina preparara en cortesia las formas de reclamos de pagos, como sea, por los servicios no se podra asumir que los cargos seran pagados por la compania de mi seguro medico. Yo comprendo que es mi responsabilidad pagar por todos los cargos que no sean cubiertos por la compania de seguros medicos, Yo tambien comprendo que en la consulta gratuita sera para determinar si sera de beneficio para mi
el tratamiento de cuidado Quiropractico, sera recomendado realizar una evaluacion y/o radio-grafias.
La evaluacion y/o las radio-grafias NO son parte de la consulta gratuita. En consecuencia,
Yo autorizo al Docotr para que revele toda la informacion necesaria para asegurar los pagos del beneficio.
Yo autorizo el uso de esta firma, y cualquier copia de esta autorizacion, en todos los formularios que se sometan a la compania de seguros medico
Yo he leido completamente y entendido lo arriba escrito.

_____

Signature of Patient/Guardian:
Firma del Paciente o Representante

Date/Fecha_____