April Macary, DC & Michael Mazzarella, DC
30 Ravenscroft Drive
Asheville, NC 28801

Date: ___________________________ Staff Name:________________

Confidential Patient Information

Patients Name: ________________________________ Chief Complaint: ___________________________

Address: _____________________________________ Home Phone: ______________________________

_____________________________________ Cell Phone: ______________________________

Social Security #: ______________________________ Email: _____________________________________

Date of Birth: __________________________ Age: _________ Marital Status: M S W D

Occupation: ___________________________________ Employer: _________________________________

Referred By (Dr. ?): ____________________________ Ins. Company: ____________________________

ID#: ___________________ Group#:____________ Ins. Phone: _________________________________

Name of Insured: ______________________________ Date of Birth: ______________________________

Are your present symptoms or conditions related to or the result of an auto collision, work-related injury or other personal injury someone else might be responsible for? ___ Yes ___ No

Family Physician: ____________________________________ Name of Facility: _____________________________

Person to contact in case of emergency (Name and Phone): ____

What operations have you had? ____ When? _________________
____ When? _________________

Serious Illness: ____ When? _________________
____ When? _________________

What medications or drugs are you taking? (check those that apply): Pain Killers ____ Insulin _____ Cholesterol Meds ___
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Other: _________________________________

What is your goal in our office? ____
Would it be okay for us to send a monthly email about your health and our events? Yes___ No___

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to April Macary, DC or Mike Mazzarella, DC all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

____ __________________________
Signature of Insured / Guardian Date