Dr. Edward Koen, D.C.
Samaritan Chiropractic, LLC
634 NW 4th Street, Corvallis Oregon 97330
541-752-0776

Patient Data

Last Name:		First Name:		MI:	Name Suffix: Jr, Sr, III, etc.
DOB:		Gender:		SS#:	
Weight:		Height:			
Marital Status: ▫ Married ▫ Other ▫ Single	Employment Status: ▫ Employed ▫ Retired ▫ Fulltime Student ▫ Unemployed ▫ Part Time Student			Professional Title:	
Preferred language:		Smoking: ▫ Yes ▫ No		Frequency:	
Race:		Ethnicity:		Religion:	
Home Address		City		State	Zip Code
Mailing Address		City		State	Zip Code
Home Phone		Work Phone		Preferred phone: ▫ Home ▫ Cell ▫ Work ▫ DO NOT CALL	
Cell Phone:		Fax:		Advanced Directive Date:	
Email:		Reminder Email: ▫ Yes ▫ No		Advance Directive Type: ▫ None ▫ Durable power of attorney ▫ Living will ▫ Do Not Resuscitate	
Confidential Communications: ▫Cell ▫ Regular mail ▫ Patient Ally ▫Home Phone ▫ Email ▫ Work Phone					
Employer Name:				Employer Phone:	
Employer Street Address:		City		State	Zip Code
Emergency Contact Name:		Emergency Contact Phone:		Relationship to Patient:	

Referred by:	Today's (or first appointment) date:

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Patient Name_____

Primary Insurance Company Name:		
Insured Last Name	Insured First Name	Insured Middle Initial
Relationship to Patient: ▫ Child ▫ Self ▫ Other ▫ Spouse	ID#: Group#: Plan Name:	Insured Date of Birth
Secondary Insurance Company Name:		
Insured Last Name	Insured First Name	Insured Middle Initial
Relationship to Patient: ▫ Child ▫ Self ▫ Other ▫ Spouse	ID#: Group#: Plan Name:	Insured Date of Birth
Tertiary Insurance Company Name:		
Insured Last Name	Insured First Name	Insured Middle Initial
Relationship to Patient: ▫ Child ▫ Self ▫ Other ▫ Spouse	ID#: Group#: Plan Name:	Insured Date of Birth

Assignment and Release

Insurance Information

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Samaritan Chiropractic LLC will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patient's/Parent's/Guardian's Signature:

Consent of Professional Services and Release of Information

I hereby authorize and release Dr. Edward Koen, DC and whomever he may designate as his assistants, to administer treatment, physical examinations, x-ray studies, laboratory procedures, chiropractic care or any clinic services that he deems necessary in my case. I furthermore authorize Dr. Koen and his assistants to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of Samaritan Chiropractic LLC's charge, including but not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patient's employer.

Patient's/Parent's/Guardian's Signature:

For Office Use Only. Do not write below this line.

Primary Ins Co	Deductible:	Visit Copay:	Insured Authorization: ▫ Y ▫ N
Secondary Ins Co	Deductible:	Visit Copay:	Insured Authorization: ▫ Y ▫ N
Tertiary Ins Co	Deductible:	Visit Copay:	Insured Authorization: ▫ Y ▫ N