Dr. William T. Norlin
Providing

Affordable
Neck & Back
Pain Relief

Nokomis Village Office
4927 34th Avenue South Suite 1B
Minneapolis, MN 55417
612-724-4647
612-729-3606 fax

Please fill this out completely (please print) Date: ______________

Name: ______________________________ Home Phone: ______________
Address: ______________________________ City: __________ Zip Code: ________
Cell Phone: ____________ E-mail: ______________________________
(For educational or promotional purposes only. We do not share or sell E-mail addresses)
Age: ____ Birth Date: ____________ Marital: S M W D How many children? ________
Occupation: ______________________ Employer: ______________________
Work Address: ______________________________ Work Phone: ______________
Name of Spouse: __________________________ Spouse's Occupation: ____________
Spouse's Employer: ______________________ Work Phone: ______________

In case of emergency, who may we contact (other than the home phone)?
Name: ____________________ Address: ____________________ Phone: ________

How did you hear about our office: ______________________________
Have you been treated for any health condition by a physician in the last year? ( ) yes ( ) no
Describe: ______________________________
Date of last physical: ______________ Doctor/Clinic Name: ______________
Remarks and additional information: ______________________________

PAYMENT IS EXPECTED AT TIME OF VISIT UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE

Person responsible for payment: ______________________ Relationship: ________
Address: ______________________________ Phone: ____________
Do you have health insurance? ( ) yes ( ) no Company: ______________________
Whose work is the health insurance through? ( ) mine ( ) spouse's
Policy/Group/ID # ______________________ Medicare # ______________________
Social Security #: ______________________ Spouse's SSN: ______________________

I understand and agree that my health and accident insurance policies are an arrangement between my insurance carrier and myself. Furthermore, I understand that The Center for Sports Biomechanics and Structural Chiropractic Medicine will prepare any necessary reports and forms to assist me in collecting any insurance monies owed for services rendered to me. I authorize the insurance company to pay The Center for Sports Biomechanics and Structural Chiropractic Medicine directly for charges submitted. I understand that the initial consultation is provided to me at no charge. I understand and agree that all subsequent services rendered are charged personally to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any outstanding fees for professional services rendered to me will be immediately due and payable. I understand that interest will accrue at the rate of 1.5% per month on the unpaid balance and I am responsible for these charges. I understand and agree that I will be liable for any and all costs incurred in collecting the amount owed. These costs may include but are not limited to: in-house collection services, attorney's fee, and collection agency services.

Patient's Signature: ______________________________ Date: ____________
or
Guardian or Spouse's Signature: ______________________ Date: ____________
Driver's License #: Expiration Date: