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 □Internet □Friend-Who may we thank_____

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 all non-covered services as well as my co-payments.

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:_____

342 Atwood Avenue Cranston, RI 02920 401.942.6967