A Body Center

Dr. Douglas Stockel, D.C.

614-A Westminster Ave
Venice, CA 90291
310.985-1515

PERSONAL INFORMATION

Patient Name:_____ Social Security #:_____
Address:_____ City_____ State_____ Zip_____
Home Phone #:_____ Cell Phone #:_____ Date of Birth:_____

Drivers License #:_____ E-mail Address:_____
Who referred you to our office:_____

EMPLOYMENT

Current employer:_____ Length of Employment:_____ Position:_____

Address:_____ Phone #:_____

Accidents:_____

Surgeries:_____

Hospitalizations:_____

Allergies:_____

Hobbies:_____

Doctors seen in the last 2 years:_____

Medications:_____

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to A Body Center, all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date signed:_____ Signature:_____

Our office procedures will be explained to you as your examination and care progress. Before we begin treatment we will discuss the results of your exam and answer any questions you have as to your condition and subsequent treatment, including risks invoked. Your signature below allows us to proceed with your care. Before you receive treatment we will get your verbal consent as well.

I the undersigned consent to proceed with care at A Body Center.

Date signed:_____Signature:_____

RECORDS RELEASE AUTHORIZATION

To:_____

Address:_____

I hereby authorize and request you to release to:

A Body Center c/o Dr. Douglas Stockel D.C.

the complete history, notes, studies and reports concerning my condition while under your care.

Date signed:_____Signature:_____