

Name _____ Birth ____ / ____ / ____

Street _____ City _____ Zip _____

Home Phone _____ Cell _____ Work _____

Type of Work _____ Employer _____

Who referred you to Dr. Brennan? _____

Medical Doctor _____ Phone _____

Name of any Specialist seen in the last 12 months _____

Would you like a copy of our privacy statement? _____

IMPORTANT INSURANCE INFORMATION

Our office is contracted with Medical Mutual of Ohio and CIGNA insurance. Please give the staff your insurance card to photo copy. **Insured's birthday** _____

Please be aware that you may have copays and/or an annual deductible required by your insurance.

I grant permission to release any information necessary to process my bills, and assign payment to Dr. Brennan.

Patient Signature _____ Date _____

NOTE: We are NOT contracted with any government programs. We CANNOT bill any secondary insurances if a government program is your primary insurance.

All non-Medical Mutual and non-CIGNA programs, or non-insurance patients will be charged \$85 for the initial visit with Dr. Brennan. All regular treatment visits are \$40. Re-exams are an additional \$10. Nutritional Consultations are \$50. These fees are to be paid during your visit.

Dr. Brennan has permission to treat my minor child: _____

Parent signature _____ Date _____