Dr. Shauna L. Olsen D.C.
Dr. Joseph D Pilloud D.C.
1699 S. Virginia Street Suite 100
Reno Nevada 89502
(775) 826-5575 Fax 775826 4494

Welcome to our Office

Name_____ Male / Female Date _____

Address _____ City _____ State _____ Zip_____

Age_____ Birthdate_____/_____/_____ Social Security # _____

Home Phone #_____ Cell Phone #_____

E-mail Address _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Employed: (circle one) F/T P/T Student Retired Employed By_____

Occupation_____ Work Phone_____

Spouse's Name_____ Spouse's Employer_____

Insurance Company Name_____ Insured is: Self / Spouse / Parent

Medical Doctor_____ Last Visit_____/_____/_____

In case of emergency, please notify:_____

Relation to you:_____ Phone #_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE..... ***CIRCLE ONE BELOW:***

Yellow Pages Drive By Patient Referral From _____ Ins Co Website Internet Other

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 and to execute such insurance claim forms and other documents on my behalf as may be necessary to receive payment. I am financially responsible for non-covered services. I agree to pay attorney fees and costs if legal action is required to collect for services. I understand that there is a FIFTEEN ($15) DOLLAR late fee that will be assessed on ALL dates of service that are 30 or more days PAST DUE and that I will continue to incur a FIFTEEN ($15) DOLLAR late fee every 30 days until the balance is paid in full.

I acknowledge that my medical records will be retained for SEVEN (7) YEARS from date of service. Any medical records older than SEVEN (7) YEARS may be destroyed.

I hereby give permission to the doctor to administer treatment and perform such procudures as he may deem necessary in the diagnosis and/or treatment of my condition.

I HAVE READ AND AGREE TO THE ABOVE

SIGNATURE_____ DATE_____

(Patient, or Parent/Guardian if Minor)