

NEW PATIENT INFORMATION

Date: _____

(Please Print)

Name: _____ Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone:(____) _____ Work Phone:(____) _____ Cell Phone: (____) _____

Social Security Number: _____ Birth date: _____

Employed by: _____ Business Address: _____

Spouse's Name: _____ Work Phone: _____

Employed by: _____ Business Address: _____

Social Security Number: _____ Referred by: _____

Parents' names if minor: _____

Have you had chiropractic care before? _____ If so, where? _____

INSURANCE DATA

Primary Insurance: _____ I.D. Number: _____

Policy holder: _____ Group Number: _____

Address and Phone: _____

Second Insurance: _____ I.D. Number: _____

Policy holder: _____ Group Number: _____

Address and Phone: _____

PATIENT AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Spouse's/Guardian's Signature: _____ Date: _____