

Patient Information

| | | | | | | | | | | | |
|--|---|------------|--------------|---------------------------|------------|-----------------|--|--|--|--|---------------------------|
| (For office use only) Date: / /200 ID#: | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">PT</td> <td style="text-align: center;">CHIRO</td> <td style="text-align: center;">W/C</td> <td style="text-align: center;">PIP</td> <td style="text-align: center;">MEDICARE</td> </tr> <tr> <td colspan="4"></td> <td style="text-align: right;"> AUTO – DOA: / / </td> </tr> </table> | PT | CHIRO | W/C | PIP | MEDICARE | | | | | AUTO – DOA: / / |
| PT | CHIRO | W/C | PIP | MEDICARE | | | | | | | |
| | | | | AUTO – DOA: / / | | | | | | | |

| | | | | | | | | | |
|----------------------------------|---------------|------------------------------|---|--|--|---------------------------|---------------|--------------------------------|----------------|
| First Name: | | Last Name: | | MI: | | | | | |
| Address: | | City: | | State: | | | | | |
| Home Phone: () | | Cell Phone: () | | Alt. Phone: () | | | | | |
| Social Security #: - - | | Date of Birth: / / | | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Male</td> <td style="text-align: center;">Female</td> </tr> <tr> <td colspan="2" style="text-align: center;">Marital Status: S M W D</td> </tr> </table> | | Male | Female | Marital Status: S M W D | |
| Male | Female | | | | | | | | |
| Marital Status: S M W D | | | | | | | | | |
| Email Address: | | | Spouse's Name: | | | | | | |
| Occupation: | | | <table style="width: 100%; border-collapse: collapse;"> <tr> <td>Presently Working:</td> <td>NO</td> <td>YES</td> <td>RETIRED</td> </tr> </table> | | | Presently Working: | NO | YES | RETIRED |
| Presently Working: | NO | YES | RETIRED | | | | | | |
| Employer Name: | | | Employer Phone: () | | | | | | |
| Employer Address: | | City: | | State: | | | | | |
| | | | | Zip: | | | | | |

| | | |
|---|---|---|
| Have you been here before? NO YES | If so, when? | Who referred you to our office? |
| Reason for visit: | Date of onset of injury/illness: | Have you been previously treated for this condition? NO YES |
| Is a referral required by your insurance? NO YES | Doctor: | Doctor Phone: () |

PRIMARY MEDICAL INSURANCE INFORMATION

(PLEASE PROVIDE THE OFFICE STAFF WITH ALL INSURANCE CARDS FOR COPYING)

| | | | |
|---|-----------------|---|--|
| Policy Holder Name: | | Date of Birth: / / | |
| Insurance Company: | | Insurance Company Phone: () | |
| Relationship to Patient: Self Spouse Child Other | | Employer Name: | |
| ID #: | Group #: | Co-pay \$ | |

SECONDARY MEDICAL INSURANCE INFORMATION

| | | | |
|---|-----------------|---|--|
| Policy Holder Name: | | Date of Birth: / / | |
| Insurance Company: | | Insurance Company Phone: () | |
| Relationship to Patient: Self Spouse Child Other | | Employer Name: | |
| ID #: | Group #: | Co-pay \$ | |

By signing this form I agree to the following. I understand & agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. 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, fees for professional services rendered me will be immediately due and payable. There will be an interest charge of 1.5% per month for any balances due in excess of 60 days. In the event of default I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

In the event that I receive a payment from the insurance company I am to turn over the payment to this office for processing.
 Patient/Guardian is responsible for any deductible/co-payment/co-pay at time of visit.

Patient's Signature _____ **Date** / /