

Patient and Insurance Information

Name:	Sex: M F	Date:
Address:	Apt #:	
City:	State:	ZIP:
Phone #s: Home:	Work:	Alt.:
SS #:	Birth Date:	Age: Email:
Marital Status M S D Other	Spouse (Partner) Name:	# of Children:
Referred By:	Age Range of Children:	
Employer:	Occupation:	
Address:		
City:	State:	ZIP:
Is this visit related to an injury: at work: Y N at home: Y N from an auto accident: Y N		
Have you ever received chiropractic care before? Y N When? Duration?		
Emergency Contact Name:	Phone:	
Primary Insurance Info		
Insurance Co. Name:	Ins Co phone:	
Address:		
City:	State:	Zip:
ID #:	Group #:	
Patient Relationship to the insured: Self Spouse Child Other		
If you are covered under another person's insurance.... Please complete		
Name of Insured:	Birth date:	Phone:
Insured's Employer:		
Secondary Insurance Info		
Insurance Co. Name:	Ins Co phone:	
Address:		
City:	State:	ZIP:
ID #:	Group #:	
Patient Relationship to the insured: Self Spouse Child Other		
If you are covered under another person's insurance.... Please complete		
Name of Insured:	Birth date:	Phone:
Insured's Employer:		

I understand that I am financially responsible for all charges and agree to pay for services. I authorize the doctor to release to my insurance company(ies) any and all information necessary to process my claim. I further authorize that payments be made directly to the physician.

Signature: _____ Date: _____