Back To Health Chiropractic

PATIENT INFORMATION WELCOME TO OUR OFFICE!

DATE: _____ PATIENT NAME: _____

SS#:_____ (FOR INSURANCE PURPOSES)

SEX: _____M _____F BIRTH DATE: _____/_____/_____ AGE: _____

FEMALES: ARE YOU PREGNANT? YES / NO IF SO: DUE DATE: _____/_____/_____

PHONE (BEST # TO REACH YOU): (_____) _____ - _____

OK TO NOTIFY YOU OF APPTS. , SPECIALS OR EVENTS VIA TEXT MESSAGING? YES / NO

IF SO, PLEASE PROVIDE CELL #: (_____) _____ - _____

EMAIL ADDRESS: _____@ _____

OK TO SEND MEDICAL INFORMATION OR OTHER CORRISPONDENCE TO EMAIL: YES / NO

ADDRESS: _____

CITY: _____STATE:_____ ZIP: _____

PATIENT EMPLOYED BY: _____

OCCUPATION: _____

BUSINESS ADDRESS: _____

BUSINESS PHONE: (_____) _____ - _____

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED_____

PHONE: (_____) _____ - _____

OKAY TO CALL THE ABOVE PHONE NUMBER TO LEAVE MESSAGES ABOUT YOUR APPOINTMENTS? YES / NO

WHAT BROUGHT YOU IN TODAY?

_____CHRONIC/NEW ONSET OF CONDITION _____WELLNESS/HEALTH MAINTENANCE

_____ SPINAL DECOMPRESSION _____WORKMAN'S COMP. _____AUTO ACCIDENT _____ SPORTS INJURY

_____ ACUPUNCTURE _____ BLOOD TESTING _____NUTRITION COUNSELING

AREA OF PAIN:

_____ NECK _____ BACK _____ HEADACHES _____ ARM/LEG/KNEE PAIN

_____ OTHER_____ _____

REFERRED TO THIS OFFICE BY:

_____INSURANCE CARRIER _____OUR WEBSITE _____WEB SEARCH _____DRIVE BY

_____REFERRAL (PLEASE LIST REFERRAL NAME SO WE CAN THANK THEM _____

PRIMARY INSURANCE

RESPONSIBLE PARTY NAME: _____

BIRTH DATE: _____/_____/_____ RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY: _____ PHONE: (_____) _____ - _____

GROUP/POLICY#:_____SUBSCRIBER ID#:_____

SECONDARY INSURANCE

RESPONSIBLE PARTY NAME: _____

BIRTH DATE: _____/_____/_____ RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY: _____ PHONE: (_____) _____ - _____

GROUP/POLICY#:_____SUBSCRIBER ID#:_____

INSURANCE ASSIGNMENT & RELEASE I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to this clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X _____ _____