PATIENT INFORMATION

First Name:________________________ Last Name:___________________________ Middle Initial.:_______
Mailing Address:____
Street Address (if different):____
City:___________________________________ State:___________ Zip Code:_____________ - __ __ __ __
Home Phone:(____) __________-__________________ Cell Phone:(____) __________-__________________
Birthdate:________/____________/____________ Age:________SSN:_________-________-_____________
Occupation:__________________________________ Employer:____
Work Address:____
Work Phone:(____) __________-__________________ Email:_______________________@______.______

Circle one.

Marital status: Single Married Widowed Divorced Legally Separated Sex: M or F
Purpose of this appointment:____
Is this visit the result of a work injury? No Yes *(if yes, please answer the questions below)*
Is this visit the result of a car accident? No Yes *(if yes, please answer the questions below)*

a) Date of Injury / Accident:___________________________
b) Claim #:____
c) Insurance Company Information:____

EMERGENCY CONTACT

First Name:________________________ Last Name:___________________________ Middle Initial.:_______
Mailing Address:____
Street Address (if different):____
City:___________________________________ State:___________ Zip Code:_____________ - __ __ __ __
Home Phone:(____) __________-__________________ Cell Phone:(____) __________-__________________
Birthdate:________/____________/____________ Age:________SSN:_________-________-_____________
Occupation:__________________________________ Employer:____
Work Address:____
Work Phone:(____) __________-__________________ Relationship to Patient:_________________________

INSURANCE INFORMATION

Insurance Company:____
Address:____
Insured's Name:_________________________________Insured's Birthdate: ________/________/_________
ID#:____ Group #:______________________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Benner Pike Chiropractic Clinic 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 Benner Pike Chiropractic Clinic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Also, I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

SIGNATURE:____ DATE:_________________
DX: