Patient Information

Welcome and thank you for choosing our office! In order to serve you properly, we need the following information. All information will be kept confidential. Please print legibly.

Date: _____ Appointment Date/Time: _____/_____ a.m / p.m. Chiro / Mms

Name: _____ Date of Birth: _____/_____/_____ Age: _____
First MI Last

What name do you prefer to be called? _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

At which number do you prefer to be contacted at (check all that apply): □ home □ work □ cell

Preferred method of reminder: Voicemail _____ Text _____

E-mail Address: _____ Can we contact you via- email? □ yes □ no

Gender: M □ F □ Occupation: _____ Employer: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Domestic Partner

Spouse's/Partner's Name:_____ # of Children: _____

Emergency Contact (name and phone #): _____

Referral Source - How did you hear about our office?): _____

What symptoms have you been experiencing? _____

Is the condition we are treating related to: □ auto accident □ work injury □ other injury

If yes please explain: _____

Have you seen another chiropractor in the past 3-5 years: □ yes □ no If so, where_____

PHONE COMMUNICATION AUTHORIZATION FOR RELEASE OF INFORMATION

I give this office permission to leave scheduling, medical and billing information at the numbers stated above:
Can we leave a message? □ yes □ no / □ at home □ at work □ on cell

** Patient's Signature: _____ Date: _____

How is patient doing paperwork? □ Online □ Coming Early □ Already filled out

Patient was informed of: OFFICE LOCATION: □ Yes □ No CANCELLATION POLICY: □ Yes □ No

C.A. _____

Over -----→

INSURANCE

Do you have insurance? □ yes □ no *** Please provide us a copy of your insurance card (s)**

Primary Insurance: _____
Insured's Name: _____
Patient's relationship to insured: □ Self □ Spouse □ Child □ Other
Insured's DOB: _____/_____/_____
Policy #: _____ Group #: _____

Secondary Insurance: _____
Insured's Name: _____
Patient's relationship to insured: □ Self □ Spouse □ Child □ Other
Insured's DOB: _____/_____/_____
Policy #: _____ Group #: _____

Credit Card #: _____ Expiration Date: _____ CV2: _____

INSURANCE AUTHORIZATION, ASSIGNMENT AND DIRECT PAYMENT FROM INSURANCE

I hereby instruct and direct the payment of all professional or medical expense benefits allowable under my current insurance policy directly to White Chiropractic as payment for professional services rendered. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I authorize the use of my signature on all insurance submissions.

If my current policy prohibits direct payment to doctor and insurance payments come directly to me, then I may either: 1) endorse the insurance check over to White Chiropractic or 2) write a personal check to White Chiropractic for the amount of payment and mail it to White Chiropractic. In either case, I will supply this office with all original (or copies of) Explanation of Benefits forms which accompany the insurance check, as the insurance company does not mail these to the clinic if I receive payment.

I authorize the release of my medical records and any information pertinent to my case to any insurance company, adjuster or attorney involved in my case. If x-rays are taken in my case, the fee paid for x-rays are for analysis only. I may authorize the films to be released for review by other medical care providers, but understand that they are the property of this office.

** Patient's Signature: _____ Date: _____