

CONFIDENTIAL PATIENT INFORMATION
PLEASE PRINT

DATE ___/___/___

PATIENT INFORMATION:

FULL NAME _____ DATE OF BIRTH ___/___/___ AGE ___ Male Female
ADDRESS _____ APT# _____ SSN ___ - ___ - ___
CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (____) _____
ALTERNATE PHONE (CELL): (____) _____ EMAIL ADDRESS: _____
EMPLOYER'S NAME _____ OCCUPATION _____
WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____
WORK PH. # (____) _____ EXT. _____ DATE SYMPTOMS BEGAN: ___/___/___
MARITAL STATUS: SINGLE MARRIED WIDOWED HOW DID YOU HEAR ABOUT US? _____
EMERGENCY CONTACT _____ PHONE _____

CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT A PERSONAL INJURY A WORK INJURY OTHER
TYPE OF CLAIM: CASH GROUP HEALTH INS PERSONAL INJURY WORKER'S COMP MEDICARE
I WILL BE PAYING TODAY BY CASH CHECK VISA MASTERCARD AMEX DISCOVER OTHER

INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF SPOUSE OTHER CHILD SPOUSE: _____
INSURED'S EMPLOYER SAME AS ABOVE _____
INSURED'S SSN SAME AS ABOVE SSN ___ - ___ - ___ INSURED'S DOB SAME AS ABOVE ___/___/___
PRIMARY INSURANCE CO. _____ ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____ PHONE#(____) _____
POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE CO. _____ ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____ PHONE#(____) _____
POLICY NUMBER _____ GROUP NUMBER _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon 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. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____
Guardian Signature: _____ Date: _____

VERIFICATION OF INSURANCE BENEFITS

IF GROUP INSURANCE: Is there coverage for Chiropractic Care? YES NO DATE ___/___/___

Plan Administered by _____ Is Doctor In Network Out of Network

Pre-Authorization Required? ? YES NO

IN NETWORK BENEFITS

Amount of Deductible: \$_____/Individual \$_____/Family
Deductible met? YES NO \$____ Remaining
Deductible Calendar or Fiscal Renewal Date ___/___/___
Max. Yearly Benefit ? \$____ Co-pay \$____ % Coverage ____
Max. Yearly Visit Limit? _____
Orthotics Coverage (CPT Code: L3030)? YES NO \$____
Exclusions/Limitations: _____
Notes: _____

OUT OF NETWORK BENEFITS

Amount of Deductible: \$_____/Individual \$_____/Family
Deductible met? YES NO \$____ Remaining
Deductible Calendar or Fiscal Renewal Date ___/___/___
Max. Yearly Benefit ? \$____ Co-pay \$____ % Coverage ____
Max. Yearly Visit Limit? _____
Orthotics Coverage (CPT Code: L3030)? YES NO \$____
Exclusions/Limitations: _____

Spoke to Whom? _____
Direct Telephone: _____

Mail Claims to: _____
Address: _____
City _____ State _____ Zip _____

IF AUTO ACCIDENT

Who was found at fault / ticketed Patient Other Driver

Insured Auto Insurance Carrier _____ Address _____
City _____ State _____ ZIP Code _____ Phone#(____) _____

POLICY NUMBER _____ CLAIM NUMBER _____
Adjuster for the Claim? _____ Coverage Verified? _____

Deductible Amount? \$ _____ Spoke to Whom? _____

Does your auto insurance coverage have Medical Payments Coverage? YES NO

If yes, Auto Insurance Carrier _____ Address _____
City _____ State _____ ZIP Code _____ Phone#(____) _____

POLICY NUMBER _____ CLAIM NUMBER _____
Adjuster for the Claim? _____ Coverage Verified? _____

Deductible Amount? \$ _____ Spoke to Whom? _____

ATTORNEY'S NAME _____ PHONE#(____) _____

IF WORKER'S COMPENSATION:

Employer's Name _____ Employer's #(____) _____

Employer's Address: _____ Is patient Currently Employed at Same? _____

Has the injury been reported? YES NO Has care been authorized? ? YES NO By whom? _____

Employer's Insurance Carrier _____ Address _____
City _____ State _____ ZIP Code _____ Phone#(____) _____

POLICY NUMBER _____ GROUP NUMBER _____