CONFIDENTIAL PATIENT INFORMATION

DATE ___/___/___

PLEASE PRINT

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: _____

Spoke to Whom?_____

Direct Telephone: _____

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: _____

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 _____