File #: ____________________

PATIENT INFORMATION

Circle One: Mr. Mrs. Ms. Miss Dr. Gender: **M F**

Full Name: ____ Suffix: ________ Nickname: ____________________

Address: ___________________________________ City: __________________ State: ______ Zip: __________

Birth Date: ____________________ Age: _________ Marital Status: **S M W D Sep** # of Children: ______

Social Security Number: ____________________

Home Phone: _________________ Cell Phone: ___________________ Email: ______________________________

How did you hear about our office? ____

Employer Information:

Employer: __________________________ Brief Description of Occupation:______________________________

Work Phone: _________________ Ext: ________ *Circle One*: **Full Time / Part Time**

School (if student): ____

Insurance Information:

Primary Insurance Company: ________________________________

Insured's Name: _________________________________ Birth Date:_________________

Insured's Employer: ______________________________

Secondary Insurance Company: ______________________________

Insured's Name: __________________________________ Birth Date: _________________

Insured's Employer: ______________________________

Briefly describe the major complaint that brings you to our office: ____

____

Is your condition due to an accident? **Y or N** Date of Accident: ________________

Is your condition work-related? **Y or N**

Method of Payment: (Circle one)

Cash Check Credit Card Access Card Medicare Work Comp. Auto Ins. BC/BS Other Insurance

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services.

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient / Parent or Guardian Signature: ____ Date: ___________________

FRESH START CHIROPRACTIC
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