INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. **PLEASE PRINT**

Today's Date ________________

Name ____ Social Security Number _______________
(Last) (First) (Middle)

Address:____
(House number and Street) (City) (State) (Zip Code)

Birth date: ___________________________ Age: ________ Male Female No. of Children ________

Occupation _____________________________________ Married Single Divorced Widowed

Phone Number: __________________ Cell Phone: _________________ Business Phone: _______________

When was the last time you saw a Chiropractor? ____

e-mail address: ___________________________________ Employed by _______________________________

Referred by: Friend __________________________ Saw Sign TV Radio Phone Book

Newspaper _____________________________________ Other ___________________________________
(Name of Newspaper Please)

How Payment will be made:

______ Cash ______ Check ______ Credit Card ______ Insurance

If Insurance what type of Insurance

_______ Workmen's Comp. _______ Health Insurance _______ Automobile Insurance ______ Other

Is your condition due to an accident? Yes_______ No_______ Date of Accident _______________________

Type of accident? Auto______ Work/On Job _____ At Home ______ Other ___________________________

Have you ever been in an Auto Accident? Past Year_____ Past 5 Years_____ Over 5 Years_____ Never _____

I (we) agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health & accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable.

Patients Signature ____ Date _______________________

or Guardian Signature ____ Date _______________________

FEE PAYABLE WHEN SERVICE RENDERED, IF UNABLE, PLEASE SPEAK TO THE DOCTOR