

# Back To Health Chiropractic

## PATIENT INFORMATION WELCOME TO OUR OFFICE!

DATE: \_\_\_\_\_ PATIENT NAME: \_\_\_\_\_

SS#: \_\_\_\_\_ (FOR INSURANCE PURPOSES)

SEX: \_\_\_ M \_\_\_ F BIRTH DATE: \_\_\_/\_\_\_/\_\_\_ AGE: \_\_\_

FEMALES: ARE YOU PREGNANT? YES / NO IF SO: DUE DATE: \_\_\_/\_\_\_/\_\_\_

PHONE (BEST # TO REACH YOU): (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

OK TO NOTIFY YOU OF APPTS. , SPECIALS OR EVENTS VIA TEXT MESSAGING? YES / NO

IF SO, PLEASE PROVIDE CELL #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_@\_\_\_\_\_

OK TO SEND MEDICAL INFORMATION OR OTHER CORRISPONDENCE TO EMAIL: YES / NO

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PATIENT EMPLOYED BY: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

BUSINESS ADDRESS: \_\_\_\_\_

BUSINESS PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED \_\_\_\_\_

PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

OKAY TO CALL THE ABOVE PHONE NUMBER TO LEAVE MESSAGES ABOUT YOUR APPOINTMENTS? YES / NO

### WHAT BROUGHT YOU IN TODAY?

\_\_\_ CHRONIC/NEW ONSET OF CONDITION \_\_\_ WELLNESS/HEALTH MAINTENANCE

\_\_\_ SPINAL DECOMPRESSION \_\_\_ WORKMAN'S COMP. \_\_\_ AUTO ACCIDENT \_\_\_ SPORTS INJURY

\_\_\_ ACUPUNCTURE \_\_\_ BLOOD TESTING \_\_\_ NUTRITION COUNSELING

**AREA OF PAIN:**

\_\_\_\_ NECK \_\_\_\_ BACK \_\_\_\_ HEADACHES \_\_\_\_ ARM/LEG/KNEE PAIN

\_\_\_\_ OTHER \_\_\_\_\_

**REFERRED TO THIS OFFICE BY:**

\_\_\_\_ INSURANCE CARRIER \_\_\_\_ OUR WEBSITE \_\_\_\_ WEB SEARCH \_\_\_\_ DRIVE BY

\_\_\_\_ REFERRAL (PLEASE LIST REFERRAL NAME SO WE CAN THANK THEM \_\_\_\_\_

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**PRIMARY INSURANCE**

RESPONSIBLE PARTY NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

GROUP/POLICY#: \_\_\_\_\_ SUBSCRIBER ID#: \_\_\_\_\_

**SECONDARY INSURANCE**

RESPONSIBLE PARTY NAME: \_\_\_\_\_

BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

GROUP/POLICY#: \_\_\_\_\_ SUBSCRIBER ID#: \_\_\_\_\_

INSURANCE ASSIGNMENT & RELEASE I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to this clinic all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X \_\_\_\_\_