Patient Information

Date: _____

Personal Information:

Name: _____ Soc. Sec. #: _____

Date of Birth: _____ Age: ___ Sex: M F Marital Status: S M D W

Mailing Address: _____ City: _____ State: ___ Zip: _____

Physical Address (no PO Box): _____ City: _____ State: ___ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ email: _____

Whom will we be contacting if we call? Self, or _____

Employer: _____ Occupation: _____

Referred by: _____ Past Chiropractic care? Y N When?: _____

Family Information:

Partner/Guardian's name: _____ Soc. Sec. # _____

Employer: _____ Work Phone: _____

Insurance Information:

Insurance Carrier: _____ Policy #: _____

Group #: _____ Effective Date: _____

Relationship to Insured: Self Spouse Child Other

Patient's or Authorized Person's Signature:
I authorize the release of any medical or other info necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.

X_____ Date:_____.

Insured or Authorized Person's Signature:
I authorize payment of medical benefits to Summerville Chiropractic for performance of Chiropractic services:

X_____ Date:_____.

Payment Information:

Method of payment (circle one): Insurance Cash Check Credit Card M/C Visa Discover # _____

Party responsible for payment: _____

Are you interested in our payment plan options? Yes No

If treatment is for a minor, who is responsible for payment? _____

Payment is due at the time services are rendered. As a service and courtesy to our patients, we currently file any insurance that provides coverage for Chiropractic care. In the event that your carrier denies payment, or when maximum benefits have been reached, you will be responsible for your account balance. It is understood and agreed that the amount paid for X-Rays is for examination only, and the X-Ray films will remain the property of this office, being on file where they may be seen at any time while a patient of this office.

_____ _____

Signature Date