

The Health & Wellness Clinic of Chiropractic
Confidential Patient Information

Date _____ Patient Name: _____

How did you hear about us? _____

Sex: M F Marital Status: Married Divorced Single Widowed

DOB: _____ Patient Social Security #: _____

Driver's License State Issued: _____ Driver's License # : _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Patient Home Ph#: _____ Patient Cell Ph#: _____

Occupation: _____ Employer's Name: _____

Work Phone #: _____ Is it OK to contact you at work? YES NO

Name of Primary Care Physician: _____

Phone #: _____ Fax #: _____

Was this a work related injury/auto accident? YES NO Date of Injury: _____

If yes, was the injury/accident reported to your insurance company? YES NO

Adjuster Name: _____ Adjuster Phone #: _____

What is the reason for your visit today? _____

What date did your symptoms begin? _____

Have you consulted anyone else for this condition? YES NO

If yes, please briefly detail who you saw and what treatment was given: _____

NAME OF NEAREST RELATIVE OR FRIEND NOT LIVING WITH YOU:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Financial Information: Person Responsible for Fees

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Social Security #: _____ Subscriber DOB: _____

Subscriber Home Phone: _____ Work Phone: _____

Address: _____

Insurance Carrier Information:

Primary Carrier Name: _____

Patient ID# (Including suffix if applicable): _____ Group #: _____

Billing address for claims: _____

Phone # for Claims: _____

Website, if Applicable: _____

Secondary Carrier Name: _____

Patient ID# (Including suffix if applicable): _____

Group #: _____ Phone # for Claims: _____

Billing address for claims: _____

*****Please provide a copy of your insurance card and photo ID so that we may have a copy on file.*****

Payment for services is due in full at the time of service, including any copays or deductible amounts. It is your responsibility as the patient/responsible party to understand your insurance and what your plan limitations are. Please feel free to ask questions at any time. Thank you for placing your trust in us.

Patient/Responsible Party Signature: _____ **Date** _____