

DC CHIROPRACTIC

1100 4 Mile Rd NW Grand Rapids, Mi 49544
Ph – (616) 301-2225 Fax – (616) 719-4593

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION - PLEASE PRINT CLEARLY

Date ___/___/___

Full Name: _____ Date of Birth: ___/___/___ Age: ___

Sex: (Circle) M / F Social Security #: ___-___-___ Marital Status: (circle) M S W D LP

Address: _____ Apt # _____ City: _____ State: ___ Zip Code _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone (____) _____ - _____

Email: _____

Emergency Contact: _____ Phone number (____) _____ - _____ Relationship: _____

Employer's Name _____ Occupation: _____

Work Address: _____ City: _____ State: ___ Zip: _____

Work phone #: (____) _____ - _____ ext. _____ How did you hear about us? _____

CLAIM INFORMATION

Is your condition due to – Auto Accident Personal injury Work Injury Other _____

Type of Claim - Cash Group Health Ins. Personal Injury Worker's Comp Medicare

I will be paying today by - Cash Check Visa MasterCard

INSURANCE INFORMATION

Relationship to insured? Self Spouse Other Child Spouse Name _____

Insured's Employer - Same as above _____

Insured's SSN - Same as Above SSN ___-___-___ Insured's DOB Same as Above ___/___/___

Primary Insurance Co. _____ Address _____

City _____ State ___ Zip Code _____ Phone # (____) _____ - _____

Policy Number _____ Group Number _____

Secondary Insurance Co. _____ Address _____

City _____ State ___ Zip Code _____ Phone # (____) _____ - _____

Policy Number _____ Group Number _____

AUTHORIZATIONS:

- I hereby authorize release of any medical information necessary to process this claim an request payment of insurance benefit payment of insurance benefits either to myself or to the party who accepts assignments
- I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
- I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____