PATIENT INFORMATION

Personal Information:

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

First Name _____ MI: ____ Last Name _____ Date: _____

Address _____

City: _____ State: _____ Zip: _____

S.S. #_____-_____-_____ Age: _____ Date of Birth: _____ Sex: M ☐ F ☐

Email: _____ Phone: (___)_____-_____ Alternate Phone # (_____)_____-_____

☐ Single ☐ Married ☐ Significant Other ☐ Widowed ☐ Separated ☐ Divorced

Employer Information:

Name of Employer: _____ Occupation: _____

Employer Address: _____

May we contact you at work: ☐ Y ☐ N Work Phone: (_____) _____-_____

Spouse/Partner Information:

First Name: _____ MI: _____ Last Name:_____ DOB: _____/_____/_____

SS#: _____-_____-_____ Spouse/Partner Employer: _____ Occupation _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: (_____)_____-_____ (Cell / Work) (_____)_____-_____

How did you learn about us?

☐ Friend or Family (name) _____ ☐ Internet Search ☐ Employer

☐ Physician (name) _____ ☐ Website ☐ Other _____

Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address? ☐ Yes ☐ No

PAYMENT INFORMATION

Person Responsible for Payment: _____ Date of Birth: _____

Social Security Number: _____-____-_____ Phone: (_____)_____-_____

Insurance Information:

Do you have health insurance? □ Yes □ No	
Primary Insurance	**Secondary Insurance**
Insurance Company:	Insurance Company:
Policy Holder's Name:	Policy Holder's Name:
Relationship to Patient:	Relationship to Patient:
Policy Holder's Birth Date:	Policy Holder's Birth Date:
Group Number:	Group Number:
Policy ID Number:	Policy ID Number:

Assignment and Release:

I, The undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to M&E Chiropractic 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 provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions

Responsible Party _____ Date _____

Accident Information:

Is the condition which brought you here today due to an accident? ☐ Y ☐ N

Date of Accident: _____

Type of Accident: ☐ Auto ☐ Work ☐ Home ☐ Other _____

To whom have you made a report of your accident?

☐Auto Insurance ☐ Employer ☐Worker' Comp ☐Other _____

Attorney Name (if applicable) _____