

Confidential Patient Information

Today's Date _____

These forms are legal documents and are necessary to bill insurance and are part of your medical chart. They must be completed in detail so please take your time and ask for assistance if you need help.

FIRST NAME _____

LAST NAME _____

ADDRESS _____

APT# _____ CITY _____

ZIP CODE: _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL _____

SEX: M F MARITAL STATUS: S M W D # OF CHILDREN _____

DATE OF BIRTH _____ SOCIAL SECURITY # _____

DRIVERS LICENSE # _____

OCCUPATION _____

EMPLOYER _____

WORK ADDRESS _____ CITY _____

SPOUSE'S NAME _____

SPOUSE'S EMPLOYER _____

1. Is this condition the result of an injury that happened at work? **Y** **N**
If yes, did you report it to your supervisor? **Y** **N**
2. Is your condition the result of auto accident? **Y** **N**
3. How do you intend on paying for today's visit? _____
4. Who referred you to our office? _____
5. Do you have health insurance that covers chiropractic? **Y** **N**
Please provide the receptionist with a copy of your insurance card.
6. How do you wish to receive appointment reminders? ☐ Phone or ☐ Email

*I understand and agree that health insurance policies are an arrangement between my insurance carrier and myself. I understand that **BodyPro!** will prepare my billings to assist me in making collections from the insurance company.*

I clearly understand and agree that I am responsible for the payment of all services rendered to me if my insurance company, for whatever reason, does not pay for treatments rendered to me.

I also understand that if I terminate my care, any professional fees for services will become due and payable.

Patient's / Guardian Signature_____
Today's Date