Patient ID: ________________

Patient Information

Name:__________________________________ Date of Birth: ______________

Address:______________________________ Telephone #: _________________
_______________________________________ Cell #:_____________________

Gender: M/F Marital Status: M/S/D/W/CU SSN______________________

Email Address:_________________________________

Employer: ____________________________ Work phone #: ________________
Occupation: ____

Person to notify in emergency: _______________________ Relationship: _________
Spouse/Partner:_________________________ Work phone: ____________________

Referred by: ____
Primary physician/Family Doctor:____

Primary Reason for Visit:

__ Consult for non-surgical spinal decompression
__ Physical Therapy
__ Chiropractic Care
__ Massage Therapy
__ All Treatment Options
__ Second Opinion

Health insurance Information

Primary Insurance Co. name: ____
Subscriber name:_____________________________ Relationship: ________________
Subscriber DOB: __________________

(Please provide us with copies of all insurance cards.)

Assignment and Release:
I, the undersigned certify that I (or my dependent) have insurance coverage with _____________________ and assign directly to Laura A. Ramirez, DC 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 doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature: ____ **Date:** _________________