

Patient ID: _____

Patient Information

Last Name: _____ First: _____ MI: _____ DOB: _____
Address: _____ City: _____ St: _____ Zip: _____
Home Ph: _____ Cell _____ Work Ph: _____ SS#: _____
Where is the best place to leave a message for you? Home _____ Work _____ Cell _____
Employer: _____ Occupation: _____
Spouse/Partner: _____ Work phone: _____
e-mail address: _____

Insurance Information

Policy Holder: _____ Relationship: _____ DOB: _____
Insurance Company: _____ ID #: _____ Group #: _____
(Please provide us with copies of all insurance cards.)

Presenting Symptoms

Reason for visit: _____ Date began: _____
Is this related to: Work injury Auto Accident Other-please describe: _____
Have you sought care from another practitioner? Y N If yes, please give name: _____
Have you lost any dates from work? Y N If yes, please give date(s): _____
Have you had any recent x-rays? Y N Date Taken: _____ Name of ordering physician: _____
Are you currently taking any medication for this condition? Y N For any other condition? Y N
Women: Are you pregnant? Y N If yes, When are you due? _____ OB/GYN _____

Other Information

Who may we thank for referring you? _____
Who is responsible for paying co pay, deductibles or unpaid insurance balances? _____
Today I will be paying by: cash _____ check _____ credit card _____
In case of emergency, who shall we contact? _____ Cell: _____
Name of nearest relative: _____ Address: _____ Ph: _____

Assignment and Release:

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to The Spinal Care and Decompression Center 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: _____