PATIENT INTRODUCTION FORM

Today's Date: _____

Last Name:	**MI:**	**First Name:**
Home Address:	City:	State: Zip:
Date Birth: Age:		Home Telephone:
Height: Weight:		Work Telephone:
Social Security No:		Employer's Name:
Drivers License No:		Marital Status (**Circle**): Single, Married, Divorced, Widowed
Your Cell Phone:		Email:

Name, Address, Relationship, and Telephone Number of your nearest adult relative (for emergencies):

_____

IS THIS VISIT RELATED TO A:

☐ Work Related Injury
☐ Sports or Recreational Injury
☐ Car Crash Injury
☐ Motorcycle-Bicycle Injury
☐ Non-Injury Symptoms
☐ School/Employment Physical
☐ Home Injury
☐ Check-up Only
☐ Other (Describe):

INSURANCE INFORMATION

Does your insurance cover Chiropractic treatment?	☐ Yes, ☐ No If yes, we need a copy of the card
If yes, indicate Insurance Company Name (Need copy of card). **If you are being seen for a work related or car accident injury we need the Claim Number and the Claims Adjusters Name. If unknown, be certain to let the front desk staff know.**	Carrier Name: _____ Address: _____ Telephone: _____ Claim Number: _____ Claim Adjusters Name:
Are you the insured person or dependent (wife/husband/child)?	☐ Insured, ☐ Dependent
If you are the insured persons dependent (spouse or child), we need the insured persons name, date of birth, social security number, and the name of the insured employers business in order to do billing.	Name of Insured Person: _____ Social Security Number: _____ Insured Date of Birth: _____ Name of Insured Employer:
What is your co-payment amount for each visit?	Amount: $
What percentage does your insurance pay?	Percentage (%):
What is your insurance deductible amount each year?	Amount: $
Have you met your deductible this year?	☐ Yes, ☐ No
Does your insurance policy limit each office payment amount?	☐ Yes, ☐ No Limit is: $
Does your insurance limit the number of office visits per year?	☐ Yes, ☐ No Number:
Does your insurance limit the amount paid per year?	☐ Yes, ☐ No Limit is: $

Our office will provide insurance billing services for you if you so desire as a courtesy. *Remember that you are ultimately responsible for any charges incurred in this office. It is your responsibility to pay any deductible amount, co-insurance, and or any other balances not paid by your insurance carrier. Your signature on this document indicates that you agree to pay for any outstanding bills incurred in this office*

IN ORDER TO KEEP OUR OFFICE OVERHEAD DOWN AND KEEP OUR PATIENT FEES REASONABLE, WE EXPECT PAYMENT AT THE CONCLUSION OF EACH TREATMENT FOR CASH PATIENTS AND THE CO-PAYMENT FOR REGULAR INSURANCE PATIENTS.

Signature of responsible party (Patient or Parent): _____ Date: _____