Choice Chiropractic & wellness

PATIENT INFORMATION

Date: _____ Social Security #: _____

Sex: ☐ Male ☐ Female Birthdate: _____ Age: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered ☐ Minor

Occupation: _____ Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____ Spouse's Birthdate: _____

In Case of Emergency, Contact: _____

Relationship: _____ Phone: _____

How did you hear about us? _____

INSURANCE

Insurance Company: _____

Policy/Member ID: _____ Group #: _____

Subscriber's Name: _____ Relationship: _____

Birthdate: _____ Social Security #: _____

Is patient covered by additional insurance? ☐ Yes ☐ No

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Jeffrey Shiflet
Name of Insurance Company

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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____