



Patient Information

Name: (First, Middle, Last) _____ Date of Birth: _____
 Address: _____ (City, State, Zip): _____
 Social Security #: _____ Sex: M F Marital Status: Single Married Widowed Divorced
 Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Name: _____
 Maiden Name: _____ Employment Status: Employed Part-time Student Full-time Student Other

Employment Information

Employer: _____ Occupation: _____
 Address: _____ (City, State, Zip): _____

Responsible Party Information

Name: _____ Date of Birth: _____
 Address: _____ (City, State, Zip): _____
 Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____
 Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____
 Insured's Date of Birth: _____ Social Security #: _____ Phone: _____
 Insurance Company: _____ Group #: _____ ID Number: _____
 Address: _____ (City, State, Zip): _____

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____
 Address: _____ (City, State, Zip): _____
 Social Security #: _____ Employer: _____ Employer Phone: _____

Person to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient: _____
 Address: _____ (City, State, Zip): _____

Is Your Illness or Injury Related to Any of the Following?

Employment Emergency Accident Auto Accident (State of Auto Accident) _____ Date: _____
 If Employment related, has employer been notified? Yes No Employer Contact Name: _____
 Employer Contact Phone and Extension: _____

How Were You Referred to Our Office?

By an Attorney By a Doctor By a Patient Yellow Pages Other
 Please print the name of your source: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.
 I hereby assign, transfer, and set over to All American Chiropractic all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____