

# All About Potential Family Chiropractic, PC

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*Welcome to our office*

Date: \_\_\_\_\_

Client #: \_\_\_\_\_

## About You

Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_ Sex: M  F   
Last First MI

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS#: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Employer Address: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Clinic Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

In Case of Emergency, please notify: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

## Responsible Party Information

*Please fill out this section if someone else is responsible for the charges incurred on your account*

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_

Billing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ SS# \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Workman's Compensation Claim?  YES  NO Auto Insurance Claim?  YES  NO Medicare or Medicaid  YES  NO

*If you marked yes to any of the above questions, please give your insurance information to the front desk*

## Spouse Information

His/Her Name: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

## Referral Information

Please tell us how you heard about our office:

Patient  **NAME OF PATIENT SO WE CAN THANK THEM!** \_\_\_\_\_

Yellow Pages  Sign  Other  *please explain:* \_\_\_\_\_

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of the visit unless other arrangements have been made.

I authorize the doctor to perform any necessary services needed during diagnosis and care in this office. I also authorize the provider to release any information required to process insurance claims on my behalf.

I agree to the terms of this form and acknowledge that the above information is accurate and true.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_