

PATIENT INFORMATION

Name: _____ Age: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ Date of Birth: _____ Gender: M / F Status: M S W D

Home Phone: _____ Cell Phone: _____

Email (for our newsletter, specials and events): _____

Employer: _____ Work Phone: _____

Occupation: _____ Employment Status: F P R If student: F or P

Spouse/Parent Name(s): _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Primary Insurance

Insured: _____

Insured's Date of Birth: _____

Ins. Company: _____

Group #: _____

ID #: _____

Secondary Insurance

Insured: _____

Insured's Date of Birth: _____

Ins. Company: _____

Group #: _____

ID #: _____

In Case of Emergency, contact: _____ Phone: _____

Who may we thank for referring you? _____

GUARANTOR / RESPONSIBLE PARTY FOR PAYMENT OF SERVICES

IF DIFFERENT FROM INSURANCE INFORMATION, please complete the following:

Name(s): _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

PLEASE READ AND SIGN

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, AT THE TIME OF SERVICE, unless other arrangements have been made in advance with this office. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I will take the responsibility for any and all costs incurred by my failure to remit for services rendered. I authorize payment of chiropractic benefits to Dr. Wally Schaeffer, DC, for chiropractic services rendered. A photocopy of this assignment is as valid as the original. I also authorize the chiropractor to release any information required in the processing of insurance.

Patient's signature: _____ Date: _____

Guardian's signature if patient is a minor: _____