DATE_____

FIRST NAME_____MIDDLE INITIAL_____LAST NAME_____

DATE OF BIRTH_____ SOCIAL SECURITY #_____

ADDRESS_____

CITY_____ ZIP CODE_____

HOME PHONE_____ CELL_____

EMAIL ADDRESS_____ MARITAL STATUS (CIRCLE) SINGLE MARRIED OTHER

EMPLOYER_____ WORK PHONE_____

EMERGENCY CONTACT_____PHONE_____

RELATIONSHIP _____

PREFERRED METHOD OF CONTACT HOME CELL WORK

HOW DID YOU HEAR ABOUT US?_____

(Please include if referred by a patient, website, insurance company, etc.)

HAVE YOU SEEN A CHIROPRACTOR, PT, OR OCCUPATIONAL THERAPIST THIS YEAR? (circle) YES NO

PRIMARY INSURANCE

INSURANCE NAME_____

POLICY ID #_____ GROUP _____

SUBSCRIBER NAME_____ SUBSCRIBER BIRTHDATE_____

SUBSCRIBER SOCIAL SECURITY #_____RELATIONSHIP TO PATIENT_____

SUBSCRIBER EMPLOYER_____ SUBSCRIBER PHONE #_____

☐ ADDRESS SAME AS PATIENT ☐ ADDRESS DIFFERENT_____

SECONDARY INSURANCE

INSURANCE NAME_____

POLICY ID #_____ GROUP _____

SUBSCRIBER NAME_____ SUBSCRIBER BIRTHDATE_____

SUBSCRIBER SOCIAL SECURITY #_____RELATIONSHIP TO PATIENT_____

SUBSCRIBER EMPLOYER_____

By signing below: 1) I consent for myself or my child to receive treatment; 2) I authorize the release of protected health information to insurance carriers and/or their agents for claims payment; 3) I authorize for services to be made directly to Cumberland Valley Chiropractic and Wellness from my primary and secondary insurance. A photocopy of this assignment is considered valid as the original.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL PAYMENTS FOR SERVICES RENDERED INCLUDING COPAYMENTS AND NON COVERED SERVICES. PAYMENT OF VISIT IS DUE AT THE TIME OF SERVICE.

_____

SIGNATURE OF PATIENT OR GUARDIAN IF UNDER 18 DATE