

# CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

DATE \_\_\_/\_\_\_/\_\_\_

## PATIENT INFORMATION:

FULL NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ AGE \_\_\_ Male  Female   
ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_  
ALTERNATE PHONE (CELL): (\_\_\_\_) \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
EMPLOYER'S NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_  
WORK ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
WORK PH. # (\_\_\_\_) \_\_\_\_\_ EXT. \_\_\_\_\_ DATE SYMPTOMS BEGAN: \_\_\_/\_\_\_/\_\_\_  
MARITAL STATUS: SINGLE  MARRIED  WIDOWED  HOW DID YOU HEAR ABOUT US? \_\_\_\_\_  
EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

## CLAIM INFORMATION:

IS YOUR CONDITION DUE TO AN AUTO ACCIDENT  A PERSONAL INJURY  A WORK-INJURY  OTHER   
TYPE OF CLAIM: CASH  GROUP HEALTH INS  PERSONAL INJURY  WORKER'S COMP  MEDICARE   
I WILL BE PAYING TODAY BY CASH  CHECK  VISA  MASTERCARD  AMEX  DISCOVER  OTHER

## INSURANCE INFORMATION:

RELATIONSHIP TO INSURED? SELF  SPOUSE  OTHER  CHILD  SPOUSE: \_\_\_\_\_  
INSURED'S EMPLOYER SAME AS ABOVE  \_\_\_\_\_  
INSURED'S SSN SAME AS ABOVE  SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ INSURED'S DOB SAME AS ABOVE  \_\_\_/\_\_\_/\_\_\_  
PRIMARY INSURANCE CO. \_\_\_\_\_ ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE#(\_\_\_\_) \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_  
\*\*\*\*\*  
SECONDARY INSURANCE CO. \_\_\_\_\_ ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE#(\_\_\_\_) \_\_\_\_\_  
POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

## AUTHORIZATIONS:

- A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- B. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
- C. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# VERIFICATION OF INSURANCE BENEFITS

**IF GROUP INSURANCE:** Is there coverage for Chiropractic Care? YES  NO  DATE \_\_\_/\_\_\_/\_\_\_

Plan Administered by \_\_\_\_\_ Is Doctor In Network  Out of Network

Pre-Authorization Required? ? YES  NO

## IN NETWORK BENEFITS

Amount of Deductible: \$\_\_\_\_\_/Individual \$\_\_\_\_\_/Family

Deductible met? YES  NO  \$\_\_\_\_ Remaining

Deductible Calendar  or Fiscal  Renewal Date \_\_\_/\_\_\_/\_\_\_

Max. Yearly Benefit ? \$\_\_\_\_ Co-pay \$\_\_\_\_ % Coverage \_\_\_\_

Max. Yearly Visit Limit? \_\_\_\_\_

Orthotics Coverage (CPT Code: L3030)? YES  NO  \$\_\_\_\_

Exclusions/Limitations: \_\_\_\_\_

Notes: \_\_\_\_\_

Spoke to Whom? \_\_\_\_\_

Direct Telephone: \_\_\_\_\_

## OUT OF NETWORK BENEFITS

Amount of Deductible: \$\_\_\_\_\_/Individual \$\_\_\_\_\_/Family

Deductible met? YES  NO  \$\_\_\_\_ Remaining

Deductible Calendar  or Fiscal  Renewal Date \_\_\_/\_\_\_/\_\_\_

Max. Yearly Benefit ? \$\_\_\_\_ Co-pay \$\_\_\_\_ % Coverage \_\_\_\_

Max. Yearly Visit Limit? \_\_\_\_\_

Orthotics Coverage (CPT Code: L3030)? YES  NO  \$\_\_\_\_

Exclusions/Limitations: \_\_\_\_\_

Mail Claims to: \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## IF AUTO ACCIDENT

Who was found at fault / ticketed Patient  Other Driver

Insured Auto Insurance Carrier \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ Phone#(\_\_\_\_) \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ CLAIM NUMBER \_\_\_\_\_

Adjuster for the Claim? \_\_\_\_\_ Coverage Verified? \_\_\_\_\_

Deductible Amount? \$\_\_\_\_ Spoke to Whom? \_\_\_\_\_

Does your auto insurance coverage have **Medical Payments** Coverage? YES  NO

If yes, Auto Insurance Carrier \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ Phone#(\_\_\_\_) \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ CLAIM NUMBER \_\_\_\_\_

Adjuster for the Claim? \_\_\_\_\_ Coverage Verified? \_\_\_\_\_

Deductible Amount? \$\_\_\_\_ Spoke to Whom? \_\_\_\_\_

ATTORNEY'S NAME \_\_\_\_\_ PHONE#(\_\_\_\_) \_\_\_\_\_

## IF WORKER'S COMPENSATION:

Employer's Name \_\_\_\_\_ Employer's #(\_\_\_\_) \_\_\_\_\_

Employer's Address: \_\_\_\_\_ Is patient Currently Employed at Same? \_\_\_\_\_

Has the injury been reported? YES  NO  Has care been authorized? ? YES  NO  By whom? \_\_\_\_\_

Employer's Insurance Carrier \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_ Phone#(\_\_\_\_) \_\_\_\_\_

POLICY NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_