

Date: _____

Trombly Chiropractic PATIENT INFORMATION

Patient ID # _____

Name _____ Date of Birth: _____

Address _____ City _____ State _____ Zip _____

Home Phone : (____) _____ Cell Phone : (____) _____ Work phone : (____) _____

Social Security Number (Necessary if needed to bill insurance) : _____

Occupation: _____ Employer: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Security Number (Necessary if needed to bill insurance) : _____

Insurance Company: 1. _____ 2. _____

How did you hear about our office? _____

Have you had past Chiropractic care? Yes No If yes, When? _____

Please let us know of any serious health concerns/issues or surgeries you have had.

If you are on any medication please list the medication and what you are taking it for.

Are your current symptoms the result of an accident? If yes, please describe the incident.

I understand and agree that if I have health and/or accident insurance, these policies are an arrangement between the insurance carrier and myself. Further, I understand that this health care provider will prepare reports and forms to assist in reimbursement from the insurance company or government assistance program. 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 my personal responsibility for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I hereby authorize the doctor to examine and treat my condition as he deems appropriate though the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed that the amount paid to the Doctor for imaging is for examination only and the negatives will remain the property of this office, being on file where they may be reviewed. I also certify that all the information I have provided on this form is complete, true and accurate to the best of my knowledge.

Patient/Guardian's Signature: _____ Date: _____