PATIENT INFORMATION

Full Legal Name: _____ **Preferred First Name:** _____

Social Security # (used for insurance purposes only**):** _____

Address_____ **Phone #**_____

City_____ **State**_____ **Zip**_____

Sex: M____ F____ **Age**_____ **Birthdate**_____-_____-_____ Married: _____

Patient Employed by_____ Occupation_____

Family Medical Doctor_____ In case of emergency notify_____ Phone_____

Whom may we thank for referring you? _____

**** Email**: _____
(Used for Patient Appointment Reminders)

Primary Area of Problem or Reason for Visit: _____

_____

_____

_____

_____

PRIMARY INSURANCE

Insurance Company_____ Phone_____
ID #_____ **Group #**_____
Full Name of Person Responsible for Account_____
Relationship to Patient_____ Birthdate_____-_____-_____ Soc. Sec._____
Street Address _____ Phone_____
City_____ State_____ Zip_____

ADDITIONAL INSURANCE

Additional insurance? Yes _____ No _____
Insurance Company_____ **Phone #**_____
I.D._____ **Group #**_____
Subscriber Name_____ Relationship to patient_____Birthdate_____-_____-_____

AGREEMENT & RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with:
(Name of insurance co.) _____
I assign directly to Cook Chiropractic all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether paid by insurance or not.
I hereby, authorize the doctor to release all information necessary to secure the payment of benefits.
I authorize the use of this signature on all insurance submissions.

X_____ _____ _____

Responsible Party Signature **Relationship** **Date**