NELSON CHIROPRACTIC

1930 North Ave., Ste 1, Spearfish, SD 57783 • 605-642-5196

Confidential Patient Information

Date_______________ Name_______________________________

Home Phone (_____)_______________ Cell Phone (_____)_______________

____
STREET ADDRESS CITY STATE ZIP

____
MAILING ADDRESS CITY STATE ZIP

IS THIS VISIT DUE TO AN ACCIDENT? ☐ YES ☐ NO ☐ AUTO ☐ WORK ☐ OTHER

Whom may we thank for referring you?_______________________________

Age__________ Birthdate_______________ Marital Status_______________

Job Title_______________ Employed By_______________ SS#_______________

Name of Nearest Relative_______________ Phone # (_____)_______________

Name of Spouse_______________________________

Would you like to receive text reminders of your appointment? ☐ YES ☐ NO

Cell Phone # (_____)_______________ Cell Phone Carrier_______________

INSURANCE

Who is responsible for this account?_______________________________

Relationship to Patient_______________ Policy Holder's Policy_______________

Insurance Co._______________________________

Group #_______________________________

Is patient covered by additional insurance? ☐ YES ☐ NO

Subscriber's Name_______________________________

Birthdate_______________ SS#_______________

Relationship to Patient_______________________________

Insurance Co._______________________________

Group#_______________________________

PAYMENT AND INSURANCE INFORMATION

If insurance is involved, please give the necessary information to the receptionist.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I also 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 for my services will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for my payment. I consent to have Manual Manipulation.

Patient Signature_______________________________ Date_______________

Spouse's or Guardian's Signature_______________________________ Date_______________