Dynamic Chiropractic & Wellness Center

PATIENT INFORMATION

DATE ________________

LAST NAME __________________________ FIRST NAME _____________________ MI _________

ADDRESS ____ APT# _____________

CITY _________________________________ STATE ________________ ZIP CODE ____________

HOME PHONE ________________ WORK PHONE ________________CELL PHONE ____________

E-MAIL ADDRESS ____

BIRTH DATE _____________________ AGE _________ SEX: M F

SOCIAL SECURITY # ________________________ DRIVERS LICENSE # _____________________

MARITAL STATUS: S M D W NAME OF SPOUSE _________________________

CHILDREN: YES NO IF YES, HOW MANY? _______________

EMPLOYER ______________________________ OCCUPATION _____________________________

DATE OF INJURY __________________
WERE YOU INJURED AT WORK? YES NO IN A CAR ACCIDENT? YES NO

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________________________

FINANCIALLY RESPONSIBLE PERSON

LAST NAME _____________________________ FIRST ________________________ MI _________
ADDRESS ____ APT# ______________
CITY __________________________________ STATE _________________ ZIP CODE __________
RELATIONSHIP TO PATIENT ______________________________________

INSURANCE INFORMATION

(You do not need to fill out this portion if you are the insured AND have your card!)
We submit claims to the primary carrier only.

INSURANCE COMPANY ____
POLICY HOLDER ____
POLICY HOLDER'S BIRTHDATE _________________________
POLICY HOLDER'S ID NUMBER ____________________________________