

Potrero Chiropractors  A Wellness Center
CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION					
Patient's last name: First: Middle:			Today's Date:		
			Marital Status:		
Social Security no.:	Home Phone: () ()	Cell Phone: () ()	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Email Address:		
City:			State:	ZIP Code:	
Occupation:		Employer Name/Address:			
Employer Phone: () ()		Employer Fax: () ()			
How did you hear about us? (Please check one box):			<input type="checkbox"/> Website	<input type="checkbox"/> Diakdibody	<input type="checkbox"/> 24 Hour Fitness
<input type="checkbox"/> Sign	<input type="checkbox"/> Print Ad	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Phonebook	<input type="checkbox"/> Friend/Family	Name:
Name of closest relative Not living with you and phone number:					

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Insurance Company Name:	Address City/State/Zip:			Insurance Phone: () ()	
Insurance Fax: () ()	Will you be paying with Insurance?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of Insured:	Insurance ID:	Birth date:	Group no.:	Policy no.:	
Relation to Insured:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.: () ()	Work phone no.: () ()

PLEASE READ BEFORE SIGNING:

I understand and agree; that health and accident insurance policies are an arrangement between my insurance carrier and myself, all services rendered to me and charged directly to me, and I am personally responsible for payment. Potrero Chiropractors will prepare any necessary reports and forms to help me collect rightful benefits from my insurance company and that any amount paid to Potrero Chiropractors will be credited to my account upon receipt. I permit this office to endorse co-issued insurance company remittance checks for the transfer of credit to my account. I hereby authorize the doctors Chiropractors and whomever designate as their assistants to administer treatment as they so deem necessary. I authorize the release of any information acquired in the course of my examination or treatment. I certify that the above information is true and correct.

Patient/Guardian signature

Date