



## Patient Information

Name \_\_\_\_\_ Date \_\_\_\_\_

I prefer to be called \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  Female  Male Email Address \_\_\_\_\_

Birth date \_\_\_\_\_ Age \_\_\_\_\_ SS # \_\_\_\_\_ Driver License # \_\_\_\_\_

Are you:  Single  Married  Divorced  Widowed  Separated  Life Partner

Children's names & ages \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birth date \_\_\_\_\_ SS# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Where may we call you?  Home  Cell  Work

Have you ever received Chiropractic Care?  Yes  No

Who may we thank for referring you to us? \_\_\_\_\_

### In Case Of Emergency – Contact

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### Insurance Information

Insurance company \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?  Yes  No

Insurance company \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

ID# \_\_\_\_\_ Group # \_\_\_\_\_ Employer \_\_\_\_\_

I hereby authorize and request my insurance company to pay directly to the Doctor the amounts due on my claim for the services rendered to my dependent or me. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize the Doctor's of Green Lake Chiropractic and whomever they may designate as their assistants to administer care, as they so deem necessary.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF CHIROPRACTIC CARE REGARDLESS OF INSURANCE COVERAGE.

Patient Signature \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

*Choose Wellness.*