Account Information

Confidential

(Please **PRINT** and complete **ALL** information)

Today's Date:	**Email Address:**

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital Status: (circle one) Single Married Divorced Widow/er Other
Is this your legal name? ❑Yes ❑No	Birth Date:	Sex ❑ Male ❑ Female	
Address:		Social Security No:	Home Phone No: ( )
City:	State: Zip:	**Cell Phone Company**:	Cell Phone No: ( )
Occupation:	Employer:		Employer Phone No: ( )
Referred By:		Race:	
Emergency Contact Name:		Emergency Contact Phone No:	
Are you here because you were involved in a motor vehicle accident? ❑ Yes ❑ No		An accident of any other type? ❑ Yes ❑ No	
Are you here because of an on-the-job injury? ❑ Yes ❑ No		If so, will you file workman's comp? ❑ Yes ❑ No	

INSURANCE INFORMATION

Person responsible for bill:	Birth Date:	Social Security Number:	Home Phone Number: ( )
Address (if different from above):		City: State:	Zip:
Name of Primary Insurance Company:		Policy Number:	Group Number:
Patient's relationship to policy holder	❑ Self ❑ Spouse ❑ Child ❑ Other		
Name of Secondary Insurance (if applicable)	Policy Holder's Name:	Policy Number:	Group Number:
Patient's relationship to secondary holder	❑ Self ❑ Spouse ❑ Child ❑ Other		

I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself – NOT between my insurance company and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company, and I request and authorize payment of benefits be made directly to Winfield Chiropractic. If mine is a regular health insurance case, I agree to pay my copay or a percentage of services as they are rendered. However, I understand that I am ultimately responsible for payment in full at this office. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable. Balances over 90 days will be charged an interest fee of 0.10% per month or a late fee.

Patient's Signature:	Date:
Guardian's Signature Authorizing Care:	Date: