Welcome To Wolf Chiropractic

Thank You For Completing This Form

Today's Date: _____

PATIENT INFORMATION

Name: _____ **Soc. Sec#** _____
Last Name **First Name** **Initial**

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone:_____ **Cell Phone:** _____ **E Mail:** _____

Age: _____ **Birth Date:** _____ **Sex:** Male/Female **Martial Status:** Single/Married/Divorced/Widowed

Occupation: _____ **Employer:** _____

Work Address: _____ **Work Phone:** _____

Emergency Contact: _____
Name/Relation to Patient **Phone**

INSURANCE INFORMATION

Person Responsible For Account: _____ **Relation To Patient** Self/Spouse/Parent/Other
Last Name First Name

Address (If Different) _____
Street City State Zip

Health Plan: _____ **Policy #** _____ **Group #** _____

ADDITIONAL INFORMATION

By Whom Were You Referred? _____

Primary Physician: _____

May We Leave A Message On Your Answering Machine?	**Yes**	**No**
May We Release Information To Your Spouce?	**Yes**	**No**
May We Call You At Work?	**Yes**	**No**

ASSIGNMENT OF BENEFITS

I hereby give indefinite authorization for payment of insurance benefits to be made directly to provider for services rendered. I hereby authorize the release of all information necessary to secure the payment of benefits. I understand that failure to provide this office with current insurance information may result in my being responsible for all charges. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered. I agree to notify this office immediately whenever I have a change in my health condition or health plan coverage in the future.

_____ **Date:** _____
Signature of Patient, Legal Guardian or Responsible party