

CHIROPRACTIC SOLUTIONS *by dr julie*

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Dr. Julie L. Lyles

PLEASE PRINT

Today's date:				Doctor:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other legal or former name:		Social Security no.:		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			E-mail address:		Home phone no.: ()		
City:		State:		Zip Code:		Cell phone no.: ()	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Name of friend/family member seen here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /		Address (if different):		Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:		Employer address:		Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Aetna		<input type="checkbox"/> Anthem		<input type="checkbox"/> Blue Cross/Blue Shield	
<input type="checkbox"/> Cigna		<input type="checkbox"/> Humana		<input type="checkbox"/> United Health Care		<input type="checkbox"/> Medicare	
<input type="checkbox"/> Medicaid		<input type="checkbox"/> Passport		<input type="checkbox"/> Other			
Subscriber's name:		Subscriber's S.S. no.:		Birth date: / /		Group no.:	
Policy no.:		Co-payment: \$					
Patient's relationship to subscriber:		<input type="checkbox"/> Self		<input type="checkbox"/> Spouse		<input type="checkbox"/> Child	
<input type="checkbox"/> Other		Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	
Policy no.:							
Patient's relationship to subscriber:		<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 (not living at same address):		Relationship to patient:	
Home phone no.:		Work phone no.:	
()		()	
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lyles Chiropractic, PLLC or my insurance company to release any information required to process my claims.</p>			
_____ <i>Patient/Guardian signature</i>		_____ <i>Date</i>	