CHIROPRACTIC SOLUTIONS by dr julie

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PLEASE PRINT

Today's date:	Doctor:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	Other legal or former name:	Social Security no.:	Birth date: / /	Age:	Sex: ❑ M ❑ 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):	❑ Dr.	❑ Insurance Plan	❑ Hospital
❑ Family_____	❑ Close to home/work	❑ Internet	❑ Insurance Co.
❑ Friend _____			

Race: ❑ Caucasian ❑ Black ❑ Asian ❑ American Indian ❑ Hispanic

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? ❑ Yes	❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No				
Please indicate primary insurance	❑ Aetna	❑ Anthem Blue Cross/Blue Shield	❑ Humana	❑ Cigna
❑ United Health Care	❑ Medicare	❑ Medicaid	❑ Passport	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy No.:	Group no.:	Co-pay: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	Group no.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Cell phone no.: ( )	Work phone no.: ( )

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.

Patient/Guardian signature *Date*