

Today's Date ____/____/____ (Please Print) PCP _____

PATIENT INFORMATION						
Patient Last Name			First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, What is your legal name?	(Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security - -	Home Phone # () -
PO Box		City	State	ZIP Code	Cell Phone # () -	
Occupation			Employer		Employer Phone # () -	
How did you hear about our office? (Please check one)						
<input type="checkbox"/> Website <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Flyer/ Mailing <input type="checkbox"/> Other _____						

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD AND ID TO THE RECEPTIONIST)					
Person Responsible for Bill:	Birth Date / /	Address (if different)		Home Phone # () -	Email Address:
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			Consent for Email Communications: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you covered by insurance for this visit? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please indicate primary insurance: _____					
Subscribers Name	Subscriber's SS # - -	Birth Date / /	ID/ Policy #	Group #	Co-Payment \$
Patient 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	ID/ Policy #	Group #	
Patient 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 Relative or Friend		Relationship to Patient	Home Phone # () -
			Work Phone # () -

◆**Health Insurance:** Although we accept insurance in this office, not all insurance companies choose to cover chiropractic. Unfortunately their first line of business is making money. If you find that it does cover the services offered in our office, we will be happy to send claims directly to your insurance company. If we find out that you're responsible for your health care expenses don't be alarmed. **Most of our patients are on one of the Chiropractic Health Care Plans** discussed above. Regardless of your situation, this is the best way to keep costs down and get you all the care you need.

The above information is true to the best of my knowledge. I authorize the doctors of All About Wellness (AAW) to provide myself or my child with reasonable and proper care according to today's standards/ I authorize my insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim. I also authorize AAW or the insurance company to release any information required to process my claim. I understand that AAW has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to AAW, I agree to forward to the office all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt. I understand that I am financially responsible for the account even though insurance may be pending on all or a portion of the charges.

Signature of Patient/ Guardian: _____ Date: _____