

Southern Trace Chiropractic Center
3465 Wedgewood Lane, The Villages, Florida 32162
(352) 205-8500

Name _____ Date _____
Address _____ City _____ State _____
Zip Code _____ E-mail Address _____
Employer _____ Business Phone _____
Address _____
Type of Work _____

Spouse's Name _____
Spouse's Employer _____ Business Phone _____

Insurance No. 1 _____ Insurance No.2 _____
Address _____ Address _____

Telephone _____ Telephone _____
Group Name _____ Group Name _____
Policy Number _____ Policy Number _____
Name of Insured _____ Name of Insured _____
Insured Soc.Sec.No. _____ Insured Soc.Sec.No. _____
Insured Date of Birth _____ Insured Date of Birth _____
Medical Doctor _____ Date of last visit _____

Person to notify in case of emergency _____
Phone _____ Relation to you _____

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment and to collect any information deemed necessary in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services. Collection of unpaid balance past 30 days will necessitate a 2.5% per month late fee.

I hereby give permission to the doctor to administer treatment and perform such general procedures as deemed necessary in the diagnosis and or treatment of my condition.

Signature _____ Date _____

I was referred by _____