

**CONFIDENTIAL PATIENT INFORMATION**

The following is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need help, please ask the receptionist.

DATE \_\_\_\_\_

Were you referred to a certain doctor in this clinic? If so, who? \_\_\_\_\_  
Who referred you? \_\_\_\_\_

Is your visit due to an accident?  YES  NO

LEGAL FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_ LAST NAME \_\_\_\_\_

PREFERRED FIRST NAME \_\_\_\_\_ HOME PHONE ( ) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

CELL PHONE ( ) \_\_\_\_\_ FAX NUMBER \_\_\_\_\_

AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ SS# \_\_\_\_\_

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

WORK PHONE ( ) \_\_\_\_\_ MAY WE CONTACT YOU AT WORK?  YES  NO

OCCUPATION \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

NAME OF NEAREST RELATIVE \_\_\_\_\_ PHONE # ( ) \_\_\_\_\_

NAME OF PARTY RESPONSIBLE FOR PAYMENT \_\_\_\_\_

DO YOU HAVE INSURANCE?  YES  NO

I GIVE THE BIRDSSELL CLINIC PERMISSION TO TRANSMIT FAXES OR E-MAILS TO ME:  YES  NO

E-MAIL ADDRESS \_\_\_\_\_

**\*PLEASE PRESENT ALL SOURCES OF INSURANCE TO THE FRONT DESK FOR VERIFICATION. WE WILL NEED TO MAKE A COPY OF YOUR INSURANCE CARD ON YOUR FIRST VISIT TO VERIFY CHIROPRACTIC BENEFITS.**

**(CLINIC POLICY REQUIRES PAYMENT ARRANGEMENTS BE MADE ON THE FIRST VISIT.)**

I understand and agree that health accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare reports and forms to assist me in making collection from the insurance company and that any authorized payments that are paid directly to this office will be credited to my account. However, I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SPOUSE OR GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_