

Thompson Family Chiropractic Clinic

Dr. Beth Thompson

Dr. Dean Thompson

Dr. Sue Copper

400 16th Street Rock Island, Illinois 61201

(309) 793-1051

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 _____