

PATIENT INFORMATION

PLEASE PRINT

DATE _____

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

MAILING ADDRESS _____ STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

E-Mail Address _____ **PATIENT SS #** _____

PHONE: HOME () _____ - _____ **WORK** () _____ - _____ **CELLULAR** () _____ - _____

BIRTH DATE _____ **AGE** _____ **MALE** _____ **FEMALE** _____

MARRIED _____ **SINGLE** _____ **WIDOWED** _____ **DIVORCED** _____

NAME OF SPOUSE _____ **# OF CHILDREN** _____ **# LIVING AT HOME** _____

PATIENT OCCUPATION _____ **EMPLOYER NAME/SCHOOL** _____

EMPLOYER ADDRESS _____ **CITY** _____

STATE _____ **ZIP** _____ **HEALTH INSURANCE NAME** _____

POLICY HOLDER'S NAME _____ **POLICY #** _____ **GROUP#** _____

POLICY HOLDER'S EMPLOYMENT/SCHOOL _____ **BIRTHDATE** _____

POLICY HOLDER'S SSI# _____ **IF STUDENT, FULL TIME** _____ **OR PART TIME** _____

MEDICARE ELIGIBLE? YES _____ NO _____ **MEDICARE #** _____

MEDICAID ELIGIBLE? YES _____ NO _____ **MEDICAID #** _____

REFERRED BY _____

GUARANTOR INFORMATION (Who is responsible for paying the bill)

GUARANTOR LAST NAME _____ **FIRST NAME** _____

BILLING ADDRESS _____ **STREET ADDRESS** _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE: () _____ - _____ **WORK ()** _____ - _____ **CELLULAR ()** _____ - _____

GUARANTOR'S OCCUPATION _____ **SS #** _____

GUARANTOR'S EMPLOYER _____ **CITY** _____

STATE _____ **ZIP** _____

IS THIS CONDITION THE RESULT OF A RECENT ACCIDENT? YES _____ NO _____

AUTO _____ **WORK** _____ **OTHER** _____ **IF OTHER, PLEASE LIST** _____

ADDITIONAL INSURANCE COVERAGE

DOES THE PATIENT HAVE OTHER INSURANCE COVERAGE? ____ YES ____ NO

IF PATIENT HAS ADDITIONAL HEALTH INSURANCE COVERAGE, PLEASE LIST BELOW:

NAME OF COMPANY _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____ INSURED'S NAME _____

INSURED'S DATE OF BIRTH _____

POLICY NUMBER _____ GROUP NUMBER _____ PATIENT'S RELATIONSHIP

TO THE INSURED ____ SELF ____ SPOUSE ____ CHILD ____ STEP CHILD ____ OTHER

ADDITIONAL COMMENTS:

I UNDERSTAND THAT A .667% SERVICE CHARGE WILL BE ADDED EACH MONTH TO THIS BALANCE ON CHARGES THAT ARE UNPAID MORE THAN 60 DAYS FROM THE SERVICE DATE. THE ANNUAL PERCENTAGE RATE OF INTERESTS IS 0%. A SERVICE CHARGE IS NOT AN INTEREST CHARGE.

I ATTEST THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

**SIGNATURE OF
PATIENT/GUARANTOR**

OFFICE USE ONLY DIAGNOSIS CODES: _____ _____ ONSET OF ILLNESS/ACCIDENT _____
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CONSENT TO TREATMENT OF A MINOR

I hereby authorize DR. MYSHKA and whoever he may designate as his assistants to administer chiropractic care as he deems necessary to my _____

(Relationship to Child)

(Print Name of Child)

Signed: _____
(Parent or Guardian)

Witnessed: _____