FAMILY CHIROPRACTIC CENTER FAYETTEVILLE

114 South College Ave, Suite A, Fayetteville, Arkansas 72701 479-442-0676

Patient Information Form

Name_____ Date_____

Address_____ Date of Birth_____ Age _____

City_____ State_____ Zip_____ SSN/Medicare Number_____

Home Phone_____ Cell Phone_____ Work Phone_____

E-Mail _____

Gender M F Married Y N Spouse's Name_____

Emergency Contact Name_____ Relationship_____ **Phone Number**_____

Address_____ City_____ State____ Zip_____

Medical Doctor Name_____ Phone Number_____

Occupation _____ Employers Name_____ FT PT

Address_____ Phone_____

Race: Caucasian ___, African American ___, American Indian ___, Asian ___, Other _____

Primary Language: English, Spanish, Other _____ **Ethnicity:** Hispanic ___ Latino ___ Other _____

Yes No Are you covered by a Group Health Plan through your current or former employment?

Yes No Are you covered by a Group Health Plan through your spouse or other family member's current or former employment?

Yes No Are you receiving Workers' Compensation (WC) benefits?

Yes No Are you filing a claim due to an Auto Accident or with a no-fault insurance or liability insurance?

Yes No Are you being treated for an injury or illness for which another party has been found responsible?

REFERRED BY _____

Primary Insurance or Guarantor Information (Who is responsible for paying the bill)

Name of Insured_____ Date of Birth_____

Insured's Address_____

City_____ State_____ Zip_____ Phone_____

Insured Employer's Name _____ Address _____

Insurance Company Name_____ Policy or Plan #_____ Group # _____

Address_____ City_____ State_____ Zip_____

Signature_____ Date_____

Secondary Insurance

Name of Insured_____ Policy or Plan Number_____

Insured's Address_____ Date of Birth_____

City_____ State_____ Zip_____ Phone_____

Insurance Company Name_____

Address_____ City_____ State_____ Zip_____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare, Medicaid Services, its' contractors or subcontractors, or my other insurance companies, any information needed for this or related Insurance claim.

Signature_____ Date_____