CONFIDENTIAL PATIENT INFORMATION

Welcome. The following information is necessary for our records. Please PRINT CAREFULLY.

Today's Date: _____/_____/_____ M Tu W Th F S

How Were You Referred To Our Office? _____

PATIENT DATA		
Last Name, First Name	Nickname (if any)	Cell Phone #
		( )
Email Address	Birth Date / Age	Work Phone #
	/	( )
Home/Mailing Street Address	City	Zip
Children? Age(s)	Gender	Status
Yes No :	M F	M S W D
Employer	Occupation	#Years Employed
Regular Physician's Name	Date of Last Medical Exam	Current Treatment?
Previous Chiropractic Care?	Chiropractor's Name	Last Chiro Visit
❒ Yes ❒ No		
Any Serious Accidents, Injuries or Illnesses?:		

INSURANCE DATA (if we don't already have)		
❒ No Insurance ❒ Health Insurance	❒ Auto Injury ❒ Medicare	❒ Work Injury
Name of Insured	ID# of Insured	Relationship to You:
		❒ Self ❒ Other
Employer of Insured	Is Condition Related To:	Group #
	❒ Employment ❒ Auto Accident	
Insurance Company	Insurance Telephone #	Adm/Adj
Claims Address (*Office Use Only*)		Claim #

Assignment of Benefits:

I authorize payment of medical benefits to the office of Gregg J. Carb, DC for the services described and submitted on my behalf.	Signed: Dated:

Please Read Carefully:

A **1.5%** MONTHLY FINANCE CHARGE (**18% PER ANNUM**) WILL APPLY TO BALANCES 30 DAYS PAST DUE (minimum monthly charge is **$0.50**). PAST DUE ACCOUNTS FORWARDED TO A COLLECTION AGENCY OR SMALL CLAIMS COURT WILL HAVE A **$35** COLLECTION FEE ADDED. OUR OFFICE WILL BILL YOUR INSURANCE; HOWEVER, SERVICES PROVIDED ARE THE EXPRESS RESPONSIBILITY OF THE PATIENT AND/OR GUARANTOR. RETURNED CHECKS WILL INCUR A SERVICE CHARGE OF **$35**. OFFICE POLICY REQUIRES *PHOTO ID* ON ALL PATIENTS CARRYING BALANCES. YOUR SIGNATURE BELOW CERTIFIES UNDERSTANDING AND AGREEMENT OF THE ABOVE.

NAME _____ DATE _____