BackCare Family Chiropractic, LLC.

351 W. Central Ave., Delaware, Oh, 43015
(740) 369-4806 (p) ~ (740) 369-4902 (f)

Acct #_____

Confidential Patient Information

Patients Name: _____ Chief Complaint: _____

Address: _____ Home Phone: _____

City: _____ Zip:_____ Cell Phone: _____

SS#: _____ Email: _____

Date of Birth: _____ Marital Status: Married [ ] Single [ ] Divorced [ ]

Sex [ ] M [ ] F Age: _____ Widowed [ ] Seperated [ ]

Occupation: _____ Employer/School _____

Address of Insured (if different than above): _____

Whom may we thank for referring you?_____

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name of Policy Holder: _____ Policy Holder Birthdate: _____

Policy Holder Employer: _____ Policy Holder SS#:_____

Patients relationship to the policy holder: [ ] Self [ ] Child [ ] Spouse

Secondary Ins. Company:_____ Ins. Phone #_____

ID#:_____ Group #: _____

Name of Policy Holder:_____ Policy Holder Birthdate: _____

Policy Holder Employer:_____ Policy Holder SS#: _____

Family Physician: _____ (Note: May we send your health information to this provider (**Y/ N**)

Physician's address & phone number_____

Person to contact in case of emergency (Name and Phone): _____

Have you ever been under Chiropractic Care? Y N If so, Who? _____

What is your goal in our office? _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **BackCare Family Chiropractic, LLC.** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. **I understand I may be billed $25 for missed or cancelled appointments when I do not provide 24 hours notice**.

I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian Date