Welcome to Wayda Go! Chiropractic

PERSONAL INFORMATION

Date _____
Name _____
Address _____
City, State, Zip Code _____
Date of Birth _____
Social Security # _____
Home Phone _____
Work Phone _____
Cellular Phone/Beeper _____
Email Address _____
Sex _____ M or F Marital Status _____ M, S, D, W, Sep. Occupation _____
Employer (Name and City) _____
How did you find out about our office? _____

CONTACT INFORMATION

Where do you prefer to receive calls? ___ Home ___Work ___Cell Phone _____
When is the best time to reach you? Time _____ Days _____
In case of emergency, who should we contact?
Name _____ Relationship _____ Home # _____ Work # _____

INSURANCE INFORMATION

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's Birthdate _____
Insured's SS # _____
Insured's Employer _____
Insured's Occupation _____
Insurance Company _____
Ins. Co. Phone # _____
Group # _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Insured's Birthdate _____
Insured's SS # _____
Insured's Employer _____
Insured's Occupation _____
Insurance Company _____
Ins. Co. Phone # _____
Group # _____

I understand that my insurance is a contract between myself and my insurance company. While I understand it is the policy of this office to file my insurance claims for me, as a service to me, I agree to be responsible for payment of all services rendered on my behalf or my dependents. .

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me.

X_____
Signature of patient (or parent if minor)