

**PATIENT INFORMATION---Please Print**

**GENERAL INFORMATION**

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
 Address \_\_\_\_\_ Care of \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ (Parent or financially responsible person)  
 Driver's License # \_\_\_\_\_ No. Children \_\_\_\_\_ Phone (Home) \_\_\_\_\_  
 Email Address \_\_\_\_\_ Phone (Work) \_\_\_\_\_  
 Cell Phone \_\_\_\_\_

Sex	M	F	Married	Single	Widowed	Divorced	Age	Date of Birth / /	Social Security Number -- --
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Employer's Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Phone \_\_\_\_\_ Occupation \_\_\_\_\_

EMPLOYED	
Full Time	Part Time
Retired	Not Employed
STUDENT	
Full Time	Part Time
Non-Student	

Spouse's Name \_\_\_\_\_ Spouse's Employer \_\_\_\_\_  
 Spouse's Date of Birth \_\_\_\_\_  
 Medical Doctor \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

**INSURANCE INFORMATION**

<p><b>Primary Insurance Company Name</b></p> <p>Insured's Name _____                  ID/Membership # _____                  Policy/Group # _____                  Provider Customer Service Phone _____</p>	<p><i>Complete only if patient is not the insured</i></p> <p>Patient's Relationship to Insured _____                  Insured's Date of Birth ____/____/____                  Insured's Employer _____</p>
<p><b>Secondary Insurance Company Name</b></p> <p>Insured's Name _____                  ID/Membership # _____                  Policy/Group # _____                  Provider Customer Service Phone _____</p>	<p><i>Complete only is patient is not the insured</i></p> <p>Patient's Relationship to Insured _____                  Insured's Date of Birth ____/____/____                  Insured's Employer _____</p>

Are you seeing the Doctor today due to a:  
 (If yes, please inform the front desk)

Work-Related Injury? Yes \_\_\_ No \_\_\_ Date of Injury \_\_\_\_\_

Auto Accident? Yes \_\_\_ No \_\_\_ Date of Injury \_\_\_\_\_

**RELEASE AND ASSIGNMENT**

I agree to treatment by my doctor and such persons of the doctor's choosing, which may include interns, preceptors, Chiropractic Assistants, etc and hereby provide my consent for treatment.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my chiropractor.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand that Pamer Chiropractic will prepare any necessary forms to assist me in submitting claims to my insurance provider and credit my account when payment is received. However, I clearly understand that all services rendered to me are charged to me and I am responsible for payment unless other arrangements are made.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_