Patient Intake Form

Date:	*Primary Physician:*		
Patient Contact Information			
Patient Name (Last, First)	*Date of Birth*	*Age*	*Gender*
			□ Male □ Female
Street Address	*City*		*Zip Code*
Phone Number	*Email Address*		
Occupation	*Employer*		
How did you hear about our clinic? (Please check the appropriate box)			
□ Doctor □ Family □ Insurance Plan □ Saw Previous Doctor □ Close to Home/Work □ Hospital □ Friend □ Yellow Pages □ Social Media □ Other: _____			
Insurance Information			
Who is the primary on the insurance plan?			
□ Self			
□ Spouse	Name:		DOB:
□ Parent	Name:		DOB:
□ Legal Guardian	Name:		DOB:
Emergency Contact			
Name	*Relationship*		*Phone Number*
Terms & Agreement			
The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any account balances. I also authorize Belmont Chiropractic or my insurance company to release any information required to process my insurance claims.			
Signature			
Patient / Parent / Guardian Signature			*Date*

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