Patient Intake Form

Patient Contact Information			
Patient Name (Last, First)	*Date of Birth*	*Age*	*Gender* □ Male □ Female
Street Address	*City*	*Zip Code*	
Phone Number □ Home □ Mobile	*Email Address*		
Occupation	*Employer*		
How did you hear about our clinic (please check any that apply)? □ Doctor □ Family □ Insurance Plan □ Yelp/Google □ Other □ Hospital □ Friend □ Social Media □ Close to Home/Work _____			
Primary Care Physician and/or Doctor's Office			
Primary Holder on Insurance Plan	*Relationship to Patient* □ Self □ Child □ Spouse □ Dependent		
Emergency Contact	*Phone Number*		

Terms of Agreement

- I attest that the above information is true to the best of my knowledge.
- I give my permission and authorization for my insurance benefits to be paid directly to Belmont Chiropractic.
- I understand that I am financially responsible for any account balances.
- I authorize Belmont Chiropractic or my insurance company to release any information required to process my insurance claims and access my benefits.

Patient Signature	
Patient / Parent / Guardian Signature	*Date of Signature*

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