PATIENT INFORMATION

Name: _____ Date of Birth:_____

Age:_____ Social Security #: _____ Driver's Lic. #_____

Street Address:_____Apt #: ____

City: _____ State: _____Zip Code: _____

Home Phone: ( ) _____Work Phone: (___)_____

e-mail_____ Number of Children_____

Sex: _____ Marital Status: _____ Spouse's Name_____

Occupation: _____ Employer: _____ Address_____

_____

FINANCIAL INFORMATION

Who is responsible for this account? (Who is the primary insured?)
_____ Relationship: _____

Insurance Company: _____

ID Number: _____ Group Number: _____

Policy Number: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above named Ins. Co. and hereby assign directly to Brian Ross, D.C. all insurance benefits, including all Insurance checks sent to the patient for services provided must be signed and brought into the doctor/ or mail directly to the office.

if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I also authorize the use of my (this) signature on all insurance submissions.

Responsible Party Signature: _____Date:_____

What is the reason for your visit? Describe all of your health concerns_____

_____

When did your symptoms first appear? _____

Since then, this condition has been :(Improving, Worsening,Unchanged):_____

ACCIDENT INFORMATION OR WORK INJURY IF NOT APPLICABLE WRITE NA

Is your condition due to an accident? _____ Date of accident: _____

Type of accident: (Auto, Work, Home, Other): _____

To whom have you made a report of your accident? (Auto Insurance, Employer, Worker Comp.)
Other: _____

If this was an accident; please explain what happened:

_____

_____