Schwenn Family Chiropractic

Welcome to the Office

Who may we thank for referring you?___________________________________

Name____Date_________________________

Address______________________________________City___________________State______Zip_________

Home/Cell Phone________________________________Work Phone_________________________________

Email___________________________________Spouse's Email_____________________________________

Date of Birth_______________________Age__________Social Security Number_______-____-_________

Marital Status M S D W Spouse/Partner's Name____

Children(s) Names and ages:____

____

Employer_____________________________________Occupation___________________________

Spouse's Employer____________________________Spouse's Occupation______________________

Emergency Contact _______________________________________Relationship_________________

Phone Number____________________________Address_____________________________________

Please check reasons for consulting our office:

________I am continuing ongoing care from another chiropractor
________I am interested in wellness and natural health care
________I am concerned about my health and looking for answers
________I want to improve my immune function
________I don't know why I'm here. Please take the time to explain to me what you do
________I have a specific condition that concerns me

INSURANCE INFORMATION

Do you have health insurance? Y N Name of Insurance Company_______________________________
Guarantor's Name__________________________________Guarantor's Date of Birth________________
I understand that **ALL** visits will be filed with my insurance company. Any 1st visit coupons/gift certificates or promotions will be deducted from my patient balance. I understand and agree that Health and accident insurance policies are an arrangement between my insurance carrier and myself

*******Please allow the front desk assistant to make a copy of your Insurance card for Verification*******

FINANCIAL POLICY

Our policy requires payment in full for all services rendered at the time of service

I understand and agree that regardless of third party liability (insurance of any kind) I am ultimately financially responsible for all charges incurred on my account. I further understand and agree that if my account is not paid Within 90 days from the date of service (and other payment arrangements have not been made) the assistance of a collection agency will be enlisted and I will be responsible for any expenses incurred in collecting my account.

Method of Payment for first visit: Cash________Check_________Credit/Debit________

By my signature, I agree to the statements above and that all information given is complete and accurate to the best of my knowledge. I understand that all information given is completely confidential.

Patient Signature____Date___________________