CATE CHIROPRACTIC CENTER

Is your visit due to an accident? Yes or No Date_____

General Information:

First Name: _____ (M.I.)_____ Last _____M/F

Address_____ APT#_____ City/State_____Zip_____

HM # _____Wk #_____Cell #_____

Email_____ D.O.B._____ Age_____

Marital Status – Single – Married – Other _____ SS# _____

No. of Children _____ Occupation_____EmployerName&#_____

Spouses Name (or parent if minor): _____ Spouse Employer&ph #_____

Emergency Contact Name and phone #:_____

Please list your current symptoms:_____

List Other Doctors Seen for this condition _____

List Medications _____

List Health Conditions You've been treated for this year? _____

List any operations you've had _____

Are you Pregnant Y or N **Referred by:** _____

Insurance / Insured Information- *please show benefit card & ID to Front desk Personnel*

Name & Group # of Current Insurance _____

Patient is the Same/Self – Husband – Wife – Child – Other of Insured

Insured Name _____ D.O.B._____

SS# _____Address _____Phone _____

Employed By _____

Secondary Insured's name _____SS#_____

Employed by _____

I understand/agree that any health and accident insurance, liability insurance or medical payments are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. I permit and authorize the release of my medical records in order to collect on a claim. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize any and all insurance proceeds for medical rendered to be paid directly to Cate Chiropractic Center, INC.

Patients Signature_____ Date _____