Insurance Company Information

Patient Name_____ Initial Visit Date_____

Insurance Company Name_____

Ins. Co. Address_____

Ins. Co. Phone_____ Accident Date/Onset of Current Condition_____

Policy Holder's Name_____ Relation to Policyholder_____

Policy #_____ Claim #_____

Attorney's Name_____ Attorney's Phone_____

Attorney's Address_____

I allow Dr. Smith to release my medical records to my insurance company and attorney. I give my insurance company, _____, direction to pay Dr. Jeffrey Smith, DC, license# CH7132, for services rendered. Please send payments to:

A Center for Well-Being
903 NW 6th Street
Gainesville, FL 32601

Patient Name_____

Patient Signature_____ Date_____

Patient's description of accident and/or reason for seeking Chiropractic Care:

_____

_____

_____

_____

_____

_____

_____

(Please use other side if you need more space)