Farmington Chiropractic
32738 Grand River Ave.
Farmington, MI 48336
P: 248-615-1381

Patient Questionnaire
Please complete the information below.

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Birthdate _____ Age _____ Gender: M ____F____ Marital Status: S M D W

Home Address: _____ City_____ State_____

Home Phone: _____Cell Phone: _____Email Address: _____

Employer: _____ Occupation: _____ Work Phone: _____

Spouse Name: _____Birthdate: _____

Emergency Contact Name: _____Phone: _____Relation to Patient: _____

Family Physician: _____ Can we send updates to your family physician? Y ____N ____

What is your health complaint today? _____

_____

Insurance Information:

Name of Primary Insurance: _____ Contract#: _____

Subscriber's Name: _____ Subscriber's Birthdate: _____

Subscriber's Address: _____ Subscriber's Phone # _____

Patient Relation to Subscriber: _____

Is this a Personal Injury (ex: auto accident) or Worker's Comp (ex. injured at work)? Y____ N____

If yes, Describe: _____

Financial Agreement:
I hereby authorize payment directly to Farmington Chiropractic and/or the provider(s) of the Clinic. I understand that if the providers of this office are not providers of my insurance, or if I am not covered by insurance, then payment for services are my full responsibility. Deductibles, co-pays and co-insurance are collected at the time of service. I agree to pay bank, credit bureau and office billing expenses for any delinquent accounts. I authorize the physicians of this office to release any information in the course of treatment to only the insurance company. I have read and fully understand this insurance assignment and agreement.

_____ _____
Patient Signature /or Legal Guardian if patient is a minor Date