Patient Information Form

Barcode/Z #:

Name: _____ **Today's Date:** _____

Please complete the Patient Information Form and the Patient Intake Questionnaire. Thank You.

Patient Information

Full Name: _____ Date of Birth: _____/_____/_____

Address: _____ Soc Sec #: _____-_____-_____

City: _____ Home Phone: _____

State: _____ Zip:_____ Cell Phone: _____

Email Address: _____

Marital Status: Single Married Widowed Divorced Do you have children? Y N how many? ___

Employer: _____ Work Phone: _____

Occupation: _____

Emergency Contact: _____ Phone: _____

Did someone refer you to our office? Y N Who referred you? _____

Spouse/Parent/Guardian Information

Full Name: _____ Date of Birth: _____/_____/_____

Address: _____ Soc Sec #: _____-_____-_____

City: _____ Home Phone: _____

State: _____ Zip:_____ Cell Phone: _____

Email Address: _____

Employer: _____ Work Phone: _____

Insurance and Primary Care Physician (PCP) Information

Company: _____ Member ID #: _____

Employer: _____ Group #: _____

Policyholder's Name: _____

Policyholder's Date of Birth: _____/_____/_____ HSA/FSA : YES NO

Relationship to Patient: self spouse mother father other

PCP Name: _____ Phone: _____

City: _____ State: _____

I hereby instruct Brumbaugh Chiropractic, LLC to bill services rendered on my behalf to my insurance company. I hereby instruct my insurance company to pay Brumbaugh Chiropractic, LLC directly for services rendered. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Patient Signature: _____ Date: _____