CHIROMAX WELLNESS CENTERS

PATIENT INFORMATION SHEET

Last Name: _____ First Name: _____ Middle Initial: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____

Birth Date: _____ SS#: _____ TDL#: _____ Marital Status: _____ Occupation: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

If Injured, indicate part of body: _____ Date/Time of Injury _____ Date last worked _____

Have you been hospitalized in the last 90 days? Yes _____ No _____ Reason _____

RESPONSIBLE PARTY: (IF INDUSTRIAL DO NOT GO BELOW THIS LINE)

Last Name: _____ First Name: _____ Middle Initial: _____ Relationship: _____

Address (If different from patient): _____ City: _____ State: _____ Zip: _____ Phone #: _____

Birth Date: _____ Sex: _____ SS#: _____ TDL#: _____ Marital Status: _____

Employer: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

INSURANCE INFORMATION:

Name of Primary Insurance: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

Policy #: _____ Plan #: _____ SS# of Insured: _____ Relationship to Insured: _____

Name of Insured: _____ Insured's Birth Date: _____ Home Phone : _____

Name of Insured's Employer: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

Name of Secondary Insurance: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone #: _____

Policy #: _____ Plan #: _____ SS# of Insured: _____ Relationship to Insured: _____

Method of Payment: Cash _____ Check _____ MasterCard/Visa _____ AMEX _____ Insurance _____ Attorney _____

Name of Attorney: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Contact: _____

************************ *Note: A $25.00 Service Charge on all returned checks.* ************************

I (for) undersigned patient, do hereby voluntarily consent to such care involving routine diagnostic procedures and medical treatment by **ChiroMax Wellness Centers.** I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatments or examinations to be rendered during this or any visit. I further authorize **ChiroMax Wellness Centers** to release to any and all agencies concerned with the payment of my charges, any and all information (including copies of my records) relating to my care and treatment. I authorize payment of medical benefits to **ChiroMax Wellness Centers** and affiliates for services rendered.

Signature: _____ **Date**: _____