Klingert Chiropractic 15850 N 35TH Ave Ste. 4 Phoenix, AZ 85053 (602) 843-3788

Please Print

PATIENT INFORMATION:

FULL NAME _____ DATE OF BIRTH ____/____/____ AGE _____ Male □ Female □

ADDRESS _____ APT# _____ Social Security # Will Be Required

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (_____) _____

CELL PHONE (_____) _____ EMAIL ADDRESS _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE (_____) _____ EXT _____ SPOUSE'S NAME _____ CHILDREN# _____

MARITAL STATUS: □ SINGLE □ MARRIED □ WIDOWED HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT _____ PHONE _____

IF ABOVE PATIENT IS A MINOR: PLEASE FILL OUT INFORMATION BELOW ON PARENT / GUARDIAN.

NAME _____ DATE OF BIRTH _____ MALE □ FEMALE □

ADDRESS _____ APT# _____ SSN Will Be Required

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE (_____) _____

EMPLOYER'S NAME _____ OCCUPATION _____

WORK ADDRESS _____ CITY _____ STATE _____ ZIP _____

WORK PHONE (_____) _____ EXT _____ MARITAL STATUS: □ SINGLE □ MARRIED □ WIDOWED

INSURANCE INFORMATION: □ Health □ Auto □ Work Comp □ Medicare □ Supplemental □ Attorney

RELATIONSHIP TO INSURED? □ SELF □ SPOUSE □ CHILD □ OTHER SPOUSE'S NAME _____

INSURED'S EMPLOYER □ SAME AS ABOVE □ OTHER _____

INSURED'S SSN □ SAME AS ABOVE SSN Will Be Required INSURED'S DATE OF BIRTH _____

PRIMARY INSURANCE CO. _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ PHONE # (_____) _____

POLICY NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE? □ NO □ YES _____

AUTHORIZATIONS:

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits to the party who accepts assignment.

B. I authorize payment of any medical benefit from third-parties for benefits submitted to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment based upon the charges submitted for products and services rendered.

C. I understand and agree that health and accident policies are an arrangement between an insurance company 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. However, I clearly understand and agree that all services rendered to me are charged products or professional services rendered will be immediately due and payable.

D. I hereby certify that the above information is true and accurate. Please file the necessary insurance claim for any service rendered in my behalf.

Patient / Guardian Signature _____ Date _____