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 ______________