

BARTUSCH CHIROPRACTIC CLINIC

Patient Introduction

Please Print _____ Date: _____
Name: _____ Social Security #: _____
Address: _____ Phone: _____
City: _____ State: _____ Zip: _____
Birth Date: _____ Age: _____ Male Female No. of Children: _____
E-mail address (if applicable): _____ Married Single Divorced Widowed
Occupation: _____ Employed by: _____
City: _____ State: _____ Zip: _____
Name of Spouse (or parent if minor): _____
Occupation: _____ Employed by: _____
City: _____ State: _____ Zip: _____
Referred by: _____ Have you had chiropractic care? ____ If so, when? _____

INSURANCE INFORMATION

How do you intend to pay for services?

Cash Check Credit Insurance Workers Comp Auto Insurance

Primary Insurance: _____

Policy #/ID: _____ Group #: _____

Subscriber Name: _____ Relationship to Patient: _____

Co-pay amount: _____ Deductible amount: _____

Are you required to have a referral or pre-authorization: _____ Is there a limit to your visits? YES NO

All information given is true and correct to the best of my knowledge. Patient's signature

Name (Printed please)

Signature

Date

Please present your insurance card for the front desk to copy for your file - Thank you