SSP Family Chiropractic

Patient Name: _____

Patient Insurance/Payment Information

Payment Information

Person responsible for payment: _____Relation to Patient: _____

Street Address: _____Apt #_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Social Security Number: _____ Date of Birth: _____

Insurance Information

Do you have health insurance? **Y** **N** Will you be using it with us? _____

Primary insurance Information:

Insurance Company: _____

Policy Holder Name and Address: _____

Policy Holder Phone Number_____

Relationship to Patient: _____Policy Holder's Date of Birth_____

Policy ID Number: _____Group Number: _____

Member /Provider services telephone number on back of your card_____

Secondary insurance Information: *If applicable*

Insurance Company: _____

Policy Holder Name and Address: _____

Policy Holder Phone Number_____

Relationship to Patient: _____Policy Holder's Date of Birth_____

Policy ID Number: _____Group Number: _____

Member /Provider services telephone number on back of your card_____

PLEASE CONTINUE TO REVERSE SIDE OF THIS FORM TO COMPLETE

Car Accident

Are you here because of a car accident? Y N *If yes, answer the rest of this section*

Auto Insurance Company: _____ Policy Number: _____

Date of Accident: _____ Claim Number: _____

Are you working with an attorney? **Y N**

Attorney name: _____

Address: _____

Phone Number: _____

Physician Name: _____ Phone number: _____

City _____ Clinic: _____

Auto Insurance Company: _____ Policy Number: _____

Referral

- *How did you hear about South St. Paul Family Chiropractic?* _____
- *Did someone refer you to Dr. Julie's office?* _____

Please note that we will be taking a copy of your insurance card and your driver's license for our records. Please have those cards available at check in today.