FAMILY HEALTH HISTORY

Relation	*Name*	*Age*	*Present/Previous Serious Illnesses*
Father			
Mother			
Brothers			
Sisters			
Children			

INSURANCE INFORMATION

Nearly all insurance policies provide chiropractic coverage, but benefits vary from company to company and from policy to policy. Therefore, although we will fill out the insurance forms, the patient is personally responsible for payment of the bill. We do accept certain insurance assignments but all insurance arrangements must be approved in advance with the business office.

Insured's Name: _____ Social Security No.: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Birth Date: _____ Insured's Sex: M F

Relationship to Insured: Self Spouse Child Other: _____

Type of insurance: Group HMO PPO Auto Workers Comp Medicare Other: _____

Insured's Employer: _____

Insured's Employer's Adderss: _____

Name of Primary Insurance Company: _____

Policy No.: _____ ID No.: _____ Group No.: _____

Name of Secondary Insurance Company: _____

Policy No.: _____ ID No.: _____ Group No.: _____

Attorney Name: _____ Phone No,: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Patient's Signature: _____ Date: _____

Signature of Parent of Guardian: _____ Date: _____