**Patient Information** Date\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_\_ Gender\_\_\_ Marital Status\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip code\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: □ Full time □ Part time □ Retired □ Self Employed □ Student □ No Employment

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your injury the result of a work or automobile accident?** □ Yes □No

**Insurance Information**

\*If you are the subscriber, you do not need to complete subscriber information

Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date\_\_\_\_\_\_\_\_\_\_\_ Name of Subscriber\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_/\_\_\_/\_\_\_\_

Relationship to patient: □ Parent □ Spouse □ Other

Worker’s Compensation/MVA information \*If Worker’s comp, WCID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Incident \_\_\_/\_\_\_/\_\_\_ Insurance Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Carrier Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Agreement**

I authorize payment of my insurance benefits to Mt Hope Chiropractic. In addition, I agree to pay my financial responsibility. I understand that deductibles, copays, and co insurance dues are to be paid at the time of service. If not paid on the date of service, it is understood that an additional fee of $10 may be added to my account, unless prior financial agreements have been agreed upon. It is understood that I am responsible for any fees for service through this office that are not covered by my insurance.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_