Back In Motion Chiropractic – Confidential Patient Questionnaire

Name: _____ Date of birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Text Reminder: Yes/ No Cell phone provider: _____

Sex: M / F Marital Status: Married / Single Social Security #: _____

Email Address: _____

Occupation: _____ Employer: _____

Do you have health insurance? _____ *(*If yes, please provide card for copying)*
Do you have accident insurance *such as AFLAC, Combined, etc?* Yes___ No___
Is the reason for your visit today:
Auto Injury: Yes/No *Work Comp Injury: Yes/No*

Emergency Contact: _____ Relationship to you: _____
Emergency Contact Phone: _____

Regular M.D. _____
Last Seen: _____ For?_____

Previous/Other Chiropractor: _____
Last Seen: _____ For? _____

How/From whom did you hear about our office? _____

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Please read & sign the following: *I, the undersigned, do hereby attest that this questionnaire has been completed true to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that insurance policies are a contract between the insurance company and the policy holder, not the doctor, and as such I am responsible to know any policy limitations that might exist. I hereby authorize Back In Motion Chiropractic to release my records as necessary to obtain any pertinent third party reimbursement and/or to other pertinent healthcare providers. I authorize my insurance carrier, if I have one, to pay benefits directly to Back In Motion Chiropractic for services I receive at this clinic. This is a direct assignment of insurance benefits.*

Signed: _____ **Dated:** _____
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