HOLMES

SPINE & SPORT

CHIROPRACTIC CLINIC INC

A New Generation of Healthcare

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please fill out these forms COMPLETELY, in ink. If you have any questions or concerns do not hesitate to ask for assistance. We will be happy to help!

Name____ SS#________________________________

Home Phone (____)__________________________________ Cell Phone(____)_______________________

Address____ Email______________________________

City____ State _______________Zip_______________

Sex ☐M ☐F Birth Date____________________ ☐ Married ☐ Separated ☐Minor ☐ Widowed ☐ Divorced

Patient Employment__________________________________ Occupation__________________________

Employers Address___________________________________ Employers Phone (____)_________________

In case of emergency who should be notified? ___________________________Phone (____)_________________

PRIMARY INSURANCE

Person Responsible for Account____

Relation to Patient ____________________Birth Date__________ SS# ___________________________

Address (If different from patient's)___________________________ Phone ___________________________

City ____ State _______________Zip_______________

Person Responsible Employed By_______________________ Occupation__________________________

Business Address____________________________________ Business Phone (____)__________________

Insurance Company ____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ____________________Birth Date__________ Relation to Patient ______________________

Address(If different from patient's)____________________________ Phone ___________________________

City ____ State _______________Zip_______________

Subscriber Employed By _____________________________ Business Phone (____)__________________

Insurance Company __________________________________ SS# ___________________________

AUTHORIZATION & RESPONSIBILITIES

I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my examination and treatment.

I hereby authorize and direct my insurance benefits to be paid directly to Holmes Spine & Sport Chiropractic. I realize that I am financially responsible for non-covered services.

My signature will also verify as my "signature on file" and verify that any information I have given is correct to the best of my knowledge.

Signature____Date_____________