

# BEEMER BACK CENTER

*Gentle Chiropractic Care*

Print & fill form out as best you can. Feel free to include attachments as needed.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex \_\_\_\_\_

SS#: \_\_\_\_\_ Marital Status: M S W D

Employer Name: \_\_\_\_\_ Work #: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse SS#: \_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Health Insurance (Name): \_\_\_\_\_ ID#: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Insured Person's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Current Complaint/Condition

Reason for visit: \_\_\_\_\_

Previous treatment for this condition: \_\_\_\_\_

When did condition begin? \_\_\_\_\_ Came on gradually \_\_\_\_\_

Is condition related to :  work  auto accident  home injury  fall

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Drugs you now take: \_\_\_\_\_

Do you suffer from any condition other than the above? \_\_\_\_\_

## Past Health History

Major Surgery/Operations: \_\_\_\_\_

Major Accident or Falls: \_\_\_\_\_

Hospitalization other than above: \_\_\_\_\_

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

I understand I am financially responsible for any balance not paid by my insurance carrier.

I also direct this office to do all acts necessary to recover all or any part of these sums payable to me.

A copy of this signature is a valid as the original.

I attest that the above information is accurate to the best of my ability.

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

**FAX TO: 479-751-6022**