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MONTGOMERY FAMILY CHIROPRACTIC

207 First Street South
Montgomery, MN 56069

Patient: _____ Birthday: _____ Sex: M / F

Current Address: _____ City: _____ State: _____ Zip: _____

Billing Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Home Phone: _____ Cell Phone:_____

Marital Status: _____ Employment Status: _____

Occupation: _____ Work Phone: _____

Employer: _____ Address: _____ City: _____

Email address: _____ (for newsletters and clinic updates)

Name of Spouse/Guardian: _____ Spouse/Guardian birthday: _____

Spouse/Guardian Employer: _____

Spouse/Guardian work phone: _____ Relationship to patient: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Females are You Pregnant? _____ If yes, How far along? _____

**How did you hear about us?**

___ Internet, ___ Radio, ___ Newspaper, ___ Phonebook, ___ Ad at the mall food court, ___ Location

OR Whom may we thank for referring you? Dr. _____ OR _____

**Insurance Information if Patient is NOT Primary Card Holder:**

Card Holder's Name: _____ ID# _____

Card Holder's Birthday: _____ Relationship to Card Holder (Spouse/Child/Other)

Insured's Employer: _____ Secondary Insurance Co. _____

Insured's Address (if different from above): _____

_____

- We invite you to discuss with us any questions regarding our service. The best health services are based on a friendly, mutual understanding between provider and patient.
- I understand and agree that you will submit my claims, however no matter what they pay **I am ultimately responsible for the charges that I incur.** I understand that if I suspend or terminate my care and treatment any fees for professional services rendered will be immediately due and payable.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to my medical status.

Patient's Signature: _____ Date: _____

Parent or Guardian Signature Authorizing Care: _____ Date: _____