SUPERIOR CHIROPRACTIC / DR. JEFF PETERSON

WELCOME

Today's Date:_____

Legal Name:_____ Nickname(name you prefer to be called):_____

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

Phone #'s Home:_____ Work:_____ Cell:_____

Sex: □M □F Age:_____ Birth Date:_____ E-mail address:_____

*Patient SS#_____ Occupation:_____

Employer:_____ Employer Address:_____

□Single □Married □Partner □Widowed □Separated □Divorced

Spouse/Partner's Name:_____ Sex: □M □F Age:_____ Birth Date:_____

*Social Security #'s are required and necessary for Medicare and Personal Injury patients. This information is strictly confidential and used only for obtaining payment.

Have you ever been to a chiropractor before? □Yes □No If yes, when?_____

Whom may we thank for referring you?_____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name_____ Relationship_____ Contact #:_____

Injury date:_____ When did your symptoms appear?_____

Is this condition due to an accident? □ Yes □ No Type of accident: □Auto □Work □Home □Play

Is this condition getting progressively worse? □ Yes □ No Is it: □ Constant □ Intermittent

Does it interfere with your: □Work □Sleep □Recreation

To whom have you reported your accident? □Auto Insurance □Employer □Worker Comp. □Other_____

HEALTH INSURANCE

Health Insurance Co._____ Are you the primary member for this insurance? □ Yes □ No

If not, who is?_____ What is their relationship to the patient:_____

Primary Member's Ins. ID#:_____ Primary Member's Birth Date:_____

Primary Member's SS#: _____ Primary Member's Address:_____

Is the patient covered by additional insurance? □ Yes □ No 2nd Insurance Co.:_____

(2nd Ins.) Primary Member's Name:_____ ID#:_____ Birth Date:_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Peterson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

X_____

Responsible Party Signature Date

DR. INITIALS_____ DATE_____