WELCOME TO SOUTHERN STATES CHIROPRACTIC

Date: _____

PATIENT INFORMATION

Last Name_____First_____Initial____Soc.Sec.#:_____

Address_____

City_____ State_____ Zip_____

Home Phone #_____ Business #_____ Cell #_____

Email _____ How would you like us to contact you: Circle one Text Or Phone

Sex☐ M ☐F Age_____ Birth Date_____☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed by_____ Occupation_____

In case of an emergency, who should be notified? _____ Phone_____

PRIMARY INSURANCE

Person responsible for account: Last Name_____ First_____ Initial___

Relation to the patient_____ Birth Date_____ Soc. Sec#:_____

Address_____ Phone_____

City_____ State_____ Zip_____

Person Responsible for account: Last Name_____ Occupation_____

Business Address_____ Business Phone_____

Insurance Company_____Group#_____

Responsible person's driver's license#_____ State_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. Faccone 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 my signature on all insurance submissions. Any and all co-payments are due prior to my office visits. I hereby give permission to the doctor to administer treatment and perform such general procedures as he may deem necessary in the diagnosis and/or treatment of my condition.

Responsible Party Signature_____ Date_____

Relationship_____