## PATIENT INFORMATION

**Legal Name**: ____________________________________________ **Age**: ________ **Date**: _________________

**Name the patient normally goes by (if different than legal name):** ___________________________________

**Address**: ___________________________________ **City**: ___________________ **State**: _____ **Zip**: ________

**Social Security #**: _____________________ **Date of Birth**: _____________ **Sex**: M / F **Status**: M S W D

**Home Phone**: ___________________________________ **Cell Phone**: ___________________________________

**Email** (for our newsletter, specials and events): ______________________________________________________

**Employer**: __________________________________________ **Work Phone**: ____________________________

**Occupation**: ______________________________________ **Employment Status**: F P R **If student**: F or P

**Spouse/Parent Name(s)**: ____________________________________________ **Date of Birth**: _____________
**Address**: ___________________________________ **City**: ___________________ **State**: _____ **Zip**: ________
**Home Phone**: ___________________________________ **Cell Phone**: ___________________________________
**Employer**: __________________________________________ **Work Phone**: ____________________________

**Primary Insurance**
**Insured**: __________________________________
**Insured's Date of Birth**: ___________________
**Ins. Company**: ____________________________
**Group #**: _________________________________
**ID #**: _____________________________________

**Secondary Insurance**
**Insured**: __________________________________
**Insured's Date of Birth**: ___________________
**Ins. Company**: ____________________________
**Group #**: _________________________________
**ID #**: _____________________________________

**In Case of Emergency, contact:** _______________________________________ **Phone:** ________________

I was referred by:
____ Family member ____ Friend ____ Physician ____ Phone book ____ Internet ____ Other

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## GUARANTOR / RESPONSIBLE PARTY FOR PAYMENT OF SERVICES

If different from insurance information, please complete the following:
Name(s): _____________________________________________________ Date of Birth: ___________________
Address: ____________________________________ City: ___________________ State: _____ Zip: ________
Home Phone: ____________________________________ Cell Phone: ___________________________________
Employer: __________________________________________ Work Phone: ______________________________

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**PLEASE READ AND SIGN**

**I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, AT THE TIME OF SERVICE, unless other arrangements have been made in advance with this office. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I will take the responsibility for any and all costs incurred by my failure to remit for services rendered. I authorize payment of chiropractic benefits to Dr. Wally Schaeffer, DC, for chiropractic services rendered. A photocopy of this assignment is as valid as the original. I also authorize the chiropractor to release any information required in the processing of insurance.**

Patient's signature: ________________________________________________________ Date: ________________
Guardian's signature if patient is a minor: ____________________________________________________________