

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. Faccione 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 _____