SILVA CHIROPRACTIC & NUTRITION

New Patient Information

Name: ____ DOB:__________ Age: __________
Last , First Middle
Address:______________________________ City: _________________ State:_____ Zip: _________

Home #:(____)_______________ Work #:(____)_______________ Other#: (___)____________________

DL#: _____________ State: ____ Sex: M F Marital Status: S M D W

E-Mail: _______________________________ Height: __________ Weight: ____________

Occupation: ________________________________ Employer:_________________________________
Spouse's Name: _____________________________ Spouse's Employer:_________________________
Spouse's Work #: (____)______________________ Spouse's Occupation: ______________________
Primary insured's DOB:? ____________________
Person responsible for this account: ____________________ Relationship to Patient:____________

Person we may contact in case of an emergency:
Name: ____________________________________
Phone #: (______)__________________________

Nearest relative not living with you:
Name: ___________________________
Phone #: (____)___________________

Who is your Primary Care Physician?: ____
Have you had Chiropractic Care in the past? Yes / No When: ___________________
Chiropractor's Name: __________________ Results: _______________________________

Who may we thank for referring you? (please check one or give friend/family member's name)

Internet Search Engine: ________ Health Insurance: _____ Location: _______ Newspaper: _______

Other:________________ Friend/Family (name): ____________________________________

Is your current condition due to an Automobile accident or Worker's Compensation injury? Yes / No
Date of Injury or Accident:________________
Have you retained an attorney? Yes / No Name and Phone # of attorney:_________________

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. HOW WOULD YOU LIKE TO MAKE PAYMENT TODAY?
Cash ____ Check____ Credit/Debit _____ *Health Insurance._____ Auto Insurance_____
***WE WILL BE HAPPY TO FILE YOUR HEALTH INSURANCE FOR YOU. HOWEVER IT IS FEDERAL LAW THAT YOU MUST PAY YOUR CO-PAY, CO-INSURANCE OR DEDUCTIBLE AT THE TIME THAT SERVICES ARE RENDERED.**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Silva Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the clinic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and **that I am personally responsible for payment. Verification of insurance benefits is not a guarantee of payment, co-pay or deductible amounts. We are VERY FREQUENTLY given incorrect information by the insurance companies.**

Patient's Signature:_________________________________ Date:___________
(Parent or guardian's signature if patient is a minor)