



WELCOME

Smithfield Chiropractic

Patient Information

Patient Name: _____ Date: _____

Address: _____

City

State

Zip

Date of Birth: _____

Gender: Male Female

Cell Phone: _____ Home Phone: _____

Patient SS#: _____ Email Address: _____

Marital Status: Single Married Divorced Widowed

Ethnicity: Hispanic/Latino Not Hispanic/ Latino Race: White American Indian/Alaskan Native Asian
 Black/ African American Pacific Isl.

Language: English Spanish Other: _____

Smoking Status: Everyday Some days Former smoker Never Smoked

Insurance/Patient Responsibility

Primary Insurance: _____ Secondary Insurance: _____

Policy # _____ Policy # _____

Policy Holder's Name _____ Policy Holders Name _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to _____ all insurance benefits, if any, otherwise, the balance is due payable, by me, for services rendered. I understand that I am financially responsible for all charges independent of insurance payments. I clearly understand and agree that all services made to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will be immediately due and payable. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third-party debt collection agency.

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.

I also authorize use of my phone number and/or email for appointment reminders. If you wish to opt out of reminders, notify us in writing.

Responsible party signature: _____ Date: _____

Emergency Contact

Name: _____ Relationship: _____

Home phone: _____ Work or Cell Phone: _____

Whom may we thank for referring you?: _____