

BRADLEY CHIROPRACTIC

PATIENT INFORMATION:

Today's Date: _____

Patient's Name: _____
Last First MI

Street Address: _____

City, ST, Zip: _____

Home Number: _____

Birth Date: _____

Cell Number: _____

Sex: M _____ F _____ Age _____

Single ___ Married ___ Widowed ___ Divorced ___

SSN: _____

Preferred language: _____

Race: _____ Ethnicity: _____

Occupation: _____

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Emergency Contact: _____

Emergency Phone Number: _____

Email Address: _____

Whom may we thank for referring you?

INSURANCE INFORMATION:

Who is responsible for account? _____

Relationship to Patient: _____

Birth Date: _____ SSN: _____

(Ins. Cont.)

Insurance Co: _____

Insurance ID #: _____

Group #: _____

Is patient covered by 2ND insurance? Y ___ N ___

If yes, Cardholder's Name: _____

Relationship to Patient: _____

Insurance Co: _____

Birth Date: _____ SSN: _____

ASSIGNMENT AND RELEASE:

I, the undersigned certify that I (or my dependent) have insurance coverage with the above named insurance company and assign directly to Shawn P. Bradley, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid 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 this signature on all insurance submissions.

Responsible Party Signature

Relationship Date

PATIENT CONDITION:

Reason for visit: _____

When did symptoms appear? _____

Is this condition getting worse? Y ___ N ___

How often do you have this pain? _____

Is it constant or come and go? _____

Does it interfere with your: Work ___ Sleep ___ Other ___

Activities or movements that are painful to perform:

Sitting ___ Walking ___ Standing ___ Bending ___ Other ___