PATIENT DATA SHEET

General Information

First Name _____ M.I._____ Last Name _____
Called Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

Sex Male Female
Marital Status Single Married Separated Divorced Widowed
Birthdate _____ / _____ / _____
Social Security _____
Referred By _____

Work Status Employed Full-time student Part-time student
Employer: _____
Job Title: _____

Payment Method:
Health Insurance Cash Worker's Comp Auto Insurance

Insurance Information – Office Use Only

Plan Carrier _____ Card Holder _____
Insurance ID _____
Group No _____
Customer Service _____
Benefits Primary Secondary Other
Effective Date ____ / ____ / _____
Is this provider in Network? Y / N

Benefit Information – Office Use Only

Contact Name: _____ Date: _____
CA Initials: _____ Time: _____

Co-Pay? Y / N Amount Per Visit $_____
Co-pay covers? Office Visit **Y / N** Manipulation **Y / N** Radiology **Y / N** Therapies **Y / N**
Deductible applied? **Y / N** IND $_____ Amt. Satisfied $_____
FAM $_____ Amt. Satisfied $_____
Is there **coinsurance**? **Y / N** _____% Insurance Covers _____ % Patient Covers
Out of Pocket Max? IND $_____ Amt Used $_____Including deductible? **Y / N**
FAM $_____ Amt. Used $_____
Max Visits per Year _____ How many exhausted? _____
Is there a dollar amount max for chiropractic? **Y / N** Amt. $_____ Amt. Used $_____

Other Information: _____
_____
_____

Reference No: _____