



Date: ___/___/___ Patient Name: _____ Sex: M F

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: ___/___/___ Age: _____

Circle one: Married /Single/Divorced /Widowed /Separated

Email: _____ Employed? Yes / No

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

How did you hear about our office? Referred by: _____ Yellow Pages / Internet / Location

Who is responsible for your bill: you and Spouse/Work Comp/Auto Ins./Medicare

INSURANCE INFORMATION

Primary Insurance Company Name: _____ Health Card # _____

Insured Person's Name: _____ Insured Date of Birth ___/___/___

Relationship to Patient: _____ Insured Employer: _____

Secondary Insurance Company Name: _____ Health Card # _____

Insured Person's Name: _____ Insured Date of Birth ___/___/___

Relationship to Patient: _____ Insured Employer: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I authorize the release of any medical or other information needed to process this claim and I understand that any amount authorized to be paid shall be paid to **Aguayo Chiropractic & Wellness, INC.**, and will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be due immediately and payable.

Patients Signature: _____ SS#: _____ Date: ___/___/___

Guardian or Spouse's Signature Authorizing Care: _____ Date: ___/___/___

•2212 BROADWATER AVE. STE. D, BILLINGS, MT 59102 •(P)406-294-5777 •(F)406-297-5778