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NORCROSS HEALTH CENTER

PATIENT INFORMATION FORM

PATIENT INFORMATION

☐ Minor ☐ Single ☐ Married

Last Name:_____ First:_____ M.I._____ Sex: ☐ M ☐ F

Date of Birth: _____ Age:_____

Address:_____ City:_____ State:_____Zip:_____

Home # _____ Cell #_____

Name of Employer:_____Phone:_____

Referred By:_____

SPOUSE INFORMATION

Last Name:_____ First:_____ M.I._____ Sex: ◯ M ◯ F

Date of Birth:_____

Address:_____ City_____State:_____ Zip:_____

Home#_____Cell #:_____

INSURANCE INFORMATION:

Does your insurance cover chiropractic care? ☐ Yes ☐ No

Will you be filing today's treatment with your insurance company? ☐ Yes ☐ No

HIPAA INFORMATION:

Instructions for our office when returning phone calls or reminding you about appointments.

I authorized the office to contact me at: ☐ Home ☐ Work ☐ Cell and may leave messages at: ☐ Home ☐ Work ☐ Cell

I authorize the office to leave detailed messages about appointments/phone calls: ☐ Yes ☐ No

If you prefer us to leave messages with a specific individual please list them below:

1._____ 2._____ 3._____

Payment in full is due at the time of service unless other arrangements have been made through this office. I understand and agree that health and accident insurance policies are an arrangement between me and the insurance company. All services provided are charged directly to me and I am personally responsible for payment. Norcross Health Center will provide any necessary forms to assist in filing claims. I also understand that if I suspend or terminate my care and outstanding balance will be due and payable immediately.

Patient (or Parent/Guardian) Signature:_____Date:_____