HealthSource Chiropractic

Appointment Date: ____________________ Appointment Time: ____________________
What part of our body is injured? ____
Describe how your injury occurred:
____
____

Any X-Rays taken in the past 2 years? (Y or N) Is patient bringing X-Rays?(Y or N)

Name: ____
(First) (Middle Initial) (Last) Street:
____________________________ City: ___________ State: ______ Zip: _________
Phone: (H) ___________ (W) ___________**Date of Birth:** _______ Age: ____ Sex: M / F
SS#: _________________________ Referred to this office by : _____________________

Your Employer: ________________________ Occupation: _________________________
Address: ____________________ City: ________________State: _______ Zip: ________
Spouse: __________Spouse's Employer:________ Marital Status:S/M/D #of Children__

Family Physician: _____________________________ Physician's Phone #: ___________
Physician's Address: ______________________ City: _________ State: ___ Zip: ______
Health Insurance: ______________________ **ID# :** ______________________________
(Please have card available)

Is the injury **Work Related? Y or N** Is the injury **Auto Related? Y or N**
If **YES** to either question, please answer the following:

Date of injury: ________________ **Location of injury:** _________________________

Insurance Carrier: _____________________ (Employers carrier if Work. Comp. injury)

Insurance mailing address: __________________ City: ________ State: ___ Zip: ______

Insurance Phone Number: (__)_________Fax#: (__)_____ Contact Person _________

WCB # ____________________________ **Claim#** ______________________________

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize HealthSource Chiropractic or insurance company to release any information required to process my claims.

X ____
PATIENT/GUARDIAN SIGNATURE DATE