CONFIDENTIAL PATIENT INFORMATION

Name: ____ Date: _________
(First) (Middle) (Last)

Address ____

City: ______________________ State: ______ Zip ______________

Phone: Home _____________ Work _____________Cell_____________

Cell Phone Provider: ____

Email ____

Sex: Male ____ Female _____ Birth Date: ___________ Age___

Patient Employed by: ____________________ Occupation _________

Work Address: ____

Spouse's Name: ___________________ Employer ________________

Whom may we thank for referring you: _______________________

In case of emergency who should be notified: _______________

Emergency phone number _____________________________________

Is your injury auto or work related? Yes ______ No______

INSURANCE INFORMATION

Please provide your Insurance and Medicare cards

Payment Method

___Cash ___Check ___ Visa ___ MasterCard ___ Discover

FINANCIAL AGREEMENT

I understand that it is my responsibility to know my insurance policy's coverage for chiropractic services and products, and anything not covered by my insurance will be my responsibility. I also agree that any charges I incur at Zimmer Chiropractic that are not paid within 30 days are subject to a 1.5% monthly service charge (18% annually). Further, I agree to pay at the time of service for any portion not covered by my insurance. Further, I agree that if I suspend or terminate my care or treatment at Zimmer Chiropractic, the total balance on my account(s) with Zimmer Chiropractic will immediately become due and payable. I also agree to pay for any legal and/or collection fees incurred by Zimmer Chiropractic due to any unpaid balance.

Signature ___________________________________ **Date:** ________
(Patient, Parent, Legal Guardian or Responsible party)