sutton CHIROPRACTIC AND MASSAGE

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## PERSONAL

Patient Name _____ Date _____
Address _____ City/State/Zip _____
Social Security Number _____ Date of Birth _____ Age _____ Gender _____
Marital Status _____ Spouse's Name _____
Home Phone _____ Cell Phone _____ Work Phone _____
Emergency Contact _____ Phone _____
Email address _____
May release information to _____
**Employer** _____ Phone _____
Address _____ City/State/Zip _____
Occupation _____
**Primary Physician** _____ Phone _____
Address _____ City/State/Zip _____

## AUTO / LI / WORKERS COMP

Complete this section only if you are not using your health insurance

Date of Injury _____ Insurance Company _____
Claim Number _____ PIP Coverage (if auto accident) Yes / No
Adjuster Name _____ Phone _____
Employer for claim (if applicable) _____
Claims Address _____

## INSURANCE

Insurance Co _____ ID _____ Group No. _____
Insurance Phone _____
Subscriber Name _____ Subscriber DOB _____ Subscriber Relationship to Patient _____

## SECONDARY INSURANCE

Insurance Co _____ ID _____ Group No. _____
Insurance Phone _____
Subscriber Name _____ Subscriber DOB _____ Subscriber Relationship to Patient _____

## REFERRAL

Whom may we thank for referring you to us? _____

How did you choose our clinic?

☐ Patient ☐ Spouse ☐ Physician ☐ Office Sign ☐ News Ad
☐ Friend ☐ Direct Mail ☐ Yellow Pages ☐ Website ☐ Attorney

### AUTHORIZATION FOR CARE OF MINOR

I authorize the doctors & staff to perform any necessary services during diagnosis and care of my child.

X _____ _____
Parent/Guardian's Signature Date

### ASSIGNMENT OF HEALTH BENEFITS

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I authorize the release of any medical information necessary to process and pay this claim. I authorize payment directly to Sutton Chiropractic and Massage of the "Health Benefits", "Medical Reimbursement" from a Third Party Payor and/or "Government Benefits" otherwise payable to me. I understand this office only accepts assignment when insurance pays directly.

X _____ _____
Parent/Subscriber's or Authorized Signature Date

### MY HEALTHCARE BENEFITS

I, _____ fully understand when the insurance company verifies my benefits, it is not a guarantee or an authorization to pay on claims submitted. I agree to pay my patient portion, plus any balance insurance does not reimburse for, at each visit. I agree to pay / settle any denied and unpaid claims. I further understand all claims submitted by this office are my responsibility and require my participation to settle regardless of my insurance company or assignment of benefits.

X _____ _____
Parent or Guarantor's Signature Date