



PATIENT INTAKE FORM

NAME _____ DATE _____

ADDRESS _____ HOME PHONE _____

CITY, STATE, ZIP CODE _____ WORK PHONE _____

DATE OF BIRTH _____ GENDER _____ M _____ F CELL PHONE _____

OCCUPATION _____ MARITAL STATUS _____ M _____ S

EMAIL ADDRESS _____ SSN# _____ - _____ - _____

EMPLOYER NAME, ADDRESS, PHONE _____

CHIEF COMPLAINT _____

SPOUSE'S NAME _____ EMPLOYER & PHONE _____

IN CASE OF EMERGENCY, CONTACT _____

RESPONSIBLE PARTY

NAME _____ RELATIONSHIP TO PT _____

HOME PHONE _____ WORK PHONE _____ ADDRESS _____

I understand that Midway Chiropractic & Health Services will seek payment for the medical charges from any major medical or other insurance coverage. If there is not coverage available, I authorize my attorney to pay the medical services from my pending claim for damages arising out of the _____. If no recovery is made on my behalf, I accept full responsibility for the charges. I authorize this office to release any information pertinent to my case, to any insurance company, adjuster or attorney, to facilitate collection under this assignment, lien and authorization.

PATIENT SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY ACCOUNT # _____ **PRIMARY DOCTOR** _____

TYPE OF FILE: AUTO _____ WORK COMP _____ MM/MC/MA _____ CASH _____ OTHER _____

INSURANCE COMPANY _____ INSURED NAME _____

PT. RELATIONSHIP TO INSURED _____

ADDRESS, CITY, STATE, ZIP _____

CLAIM # _____ DATE OF INJURY _____

CONTACT PERSON _____ PHONE _____

EMPLOYER AT TIME OF WORK COMP INJURY _____

ATTORNEY NAME _____ PHONE _____