Rose Chiropractic, Inc

Thank You for Updating Your Information…

Today's Date: _____ File #: _____ Office Use Only

Patient Name: _____

LAST FIRST MI

What You Prefer To Be Called: _____ Male _____ Female _____

Birthdate: _____ SS#: _____

Mailing Address: _____

ADDRESS CITY STATE ZIP

Home Phone #: _____ Work Phone #: _____

Other Phone #: _____ E-Mail Address: _____

Status: Minor _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

INSURANCE INFO _____ **See copy of card** _____ **Secondary Insurance?**

Company Name: _____

Address: _____

ADDRESS CITY STATE ZIP

Phone #: _____ Contract ID #: _____ Insured's SS#: _____

Group #: _____

Insured's Name: _____ Relation: _____ Date of Birth: _____

Insured's Employer: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. (Initials) _____

APPOINTMENT REMINDERS:

We will begin sending appointment reminders to better serve you, please tell us how you would prefer to get your reminders

_____ Phone _____ Email _____ Text (texting fees apply) _____ None

MEDICAL UPDATE **ALLERGIES:** _____

Medical Conditions: _____

_____

_____

Current medications: _____

_____

_____

Surgical History: _____

_____

_____

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the physician. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:_____ **Date:**_____

Responsible Party

2941-B Zelda Road, Montgomery, AL 36106

Office: 334.264.7948 • Fax: 334.264.8616