FROST CHIROPRACTIC & REHABILITATION
PATIENT INFORMATION FORM

So we may better serve you with new technology with email appointments and reminders, voice mail, text messages, & Facebook updates.

NAME: _____ GENDER M F

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE#: (_____) _____-_____ CELL#: (_____) _____-_____

DATE OF BIRTH: _____/_____/_____ SS#: _____-_____-_____

EMAIL: _____ FACEBOOK: _____

OCCUPATION: _____EMPLOYER: _____

WORK ADDRESS: _____CITY: _____STATE: _____

WORK PHONE#: (_____) _____-_____ EXT: _____

SPOUSE'S NAME: _____ CONTACT#: (_____) _____-_____

WHOM MAY WE THANK FOR REFERRING YOU TO US? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

INSURANCE CO: _____ POLICY#: _____ GRP#: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in my insurance claim and payments will be credited to my account. However, all deductibles, co-pays and co-insurance are my responsibility. We will bill your insurance twice on your behalf. However, if payment is not received, the bill will be forwarded to you and payment will then become your responsibility.

I also understand that I am responsible for all charges on the day service is rendered. If billing is necessary and payment is not received by the due date, a 15% collection fee will be added for each month payment is delinquent. Checks returned to this office for insufficient funds are liable under law for three times the amount.

SIGNATURE _____ DATE _____