St. Marys Chiropractic Offices
1297 E. Spring St.
St. Marys, OH 45885

PATIENT INFORMATION

Date: _____

(Please Print)
Name:_____ Marital Status:_____ Date of Birth: _____

Address: _____City: _____ State: _____Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

SS#: _____ Employed by: _____

Spouse's Name:_____ Date of Birth: _____Cell Phone: (_____)_____

SS#: _____ Employed by:_____

If Minor Father's Name: _____Date of Birth:_____ Cell Phone: (_____)_____

SS#: _____ Employed by: _____

If Minor Mother's Name _____ Date of Birth: _____ Cell Phone: (_____)_____

SS#: _____ Employed by: _____

Family Physician:_____ Can we release information to this physician? _____

INSURANCE DATA

Primary Insurance: _____Phone Number: _____

Group Number: _____ I.D. Number: _____

Policyholder: _____ Policyholder's Date of Birth: _____

Address of Policyholder (If different from patient): _____

Secondary Insurance:_____ Phone Number: _____

Group Number: _____ I.D. Number: _____

Policyholder: _____ Policyholder's Date of Birth: _____

Address of Policyholder (If different from patient): _____

ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

I, the undersigned, have insurance with the above captioned, and hereby assign and convey directly to St. Marys Chiropractic Offices all medical benefits and/or insurance reimbursement. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I hereby authorize the doctor to release all medical information necessary to process this claim. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company. I understand that if my health insurance requires pre-certification, it is my responsibility to notify this office.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____
Signature of Patient/Guardian Date