



BOLTON CHIROPRACTIC

WELCOME

ACCOUNT NO. _____

PATIENT INFORMATION

(Please Print)

NAME _____ SS# _____
First Middle Initial Last

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

BIRTHDATE _____ SEX: Male - Female MARITAL STATUS: M S W D

HOME PHONE _____ CELL PHONE _____ E-MAIL _____

EMPLOYER _____ OCCUPATION _____ WORK PHONE _____

SPOUSE'S NAME _____ EMPLOYER _____ WORK PHONE _____

REFERRED BY? _____ EMERGENCY CONTACT _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ EMPLOYER _____ CONTRACT# _____

NAME OF INSURED _____ DOB _____ SS# _____

RELATIONSHIP TO PATIENT _____ PHONE _____

SECONDARY INSURANCE _____ EMPLOYER _____ CONTRACT# _____

NAME OF INSURED _____ DOB _____ SS# _____

RELATIONSHIP TO PATIENT _____ PHONE _____

RESPONSIBLE PARTY (If different from above)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

RELATIONSHIP TO PATIENT _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ OFFICE PHONE _____

HEALTH HISTORY

Present Symptoms? _____

Other Doctor's seen for this condition? _____

Please list any tests, procedures, or treatments you have had for this condition.(MRI, CT, Surgery, Medications, Therapy, Injections)

Is this condition related to an auto accident? _____ Work Related? _____

List any Surgeries you have had and dates they were performed.

List any bone fractures, injuries or falls and dates they occurred. _____

Please list any medications or vitamins you are taking. _____

Do you smoke? _____ How much per day? _____

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health or change in insurance benefits. I certify that I, and/or my dependent(s), have insurance coverage with _____ (name of insurance company) and assign directly to Dr. Bolton all insurance benefits, if any, otherwise whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand and agree that health and accident insurance policies are an agreement between an insurance Carrier and myself. Furthermore, I understand that Bolton Chiropractic will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Bolton Chiropractic will be credited to my account on receipt. 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 also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. In the event I fail to pay the amounts when due, I understand that I will be in default of our agreement. Delinquency and default: I agree to pay the costs incurred to collect this bill in the event of my default in payment, including your reasonable attorney's fees.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient