Action Chiropractic, LLC (203) 456-1376

Race (Please √ one): ☐ American Indian or Alaska Native ☐ Asian or Pacific Islander ☐ Black/African American ☐ Hispanic ☐ White/Caucasian ☐ Unknown ☐ Prefer not to answer

Ethnicity (Please √ one): ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ I prefer not to answer

Primary Language (preferred spoken language): ___________________________________ ☐ I prefer not to answer

May we leave messages about your care and appointments on your home answering machine? Yes No, on your cell? Yes No

Patient First Name: ______________________ **MI** ___

Patient Last Name: ___________________________

Street Address: __________________________

City: ___________________________

State, Zip Code: ___________________________

Patient Date of Birth: _______________________

Patient Social Security Number _____________________

Patient's Home Phone # ( ) _________________

Patient's Work Phone # ( ) _________________

Patient's Cell Phone # ( ) _________________

Patient Email Address: ________________________

Patient Sex: _______ Male ______ Female

Marital Status (please circle): (child) S M D W

Occupation: ___________________________

Employer Name: _____________________________

Employer Address: _____________________________

Spouse Name: ____________________________

Emergency Contact: _____________________________

Employer Phone # ____________________________

Is this MVA? If so Date of Accident ____________________

Is this Work Comp.? If so Date of Injury __________________

Insurance Information

Primary Insurance Information: **Relationship to Patient:** ___________________

Insurance Company Name and Address:____

Policy ID #:____

Group Number: _____________________________________

Policy Holder Name: _______________________________

Policy Holder Social Security # :______________________

Policy Holder Address: ____________________________

Policy Holder Date of Birth: ________________________

Policy Holder Employer: ____________________________

Employer Phone Number: ________________________

Secondary Insurance Information: **Relationship to Patient:** _________________

Insurance Company Name and Address:____

Policy ID #:____

Group Number: ____________________________________

Policy Holder Name: _______________________________

Policy Holder Social Security # ______________________

Policy Holder Address: ____________________________

Policy Holder Date of Birth: ________________________

Policy Holder Employer: ____________________________

Employer Phone Number: ________________________

Financial and Privacy Policy and Permission to Treat ***(Please Read Carefully)***

Charges for services are due and payable by the patient / guardian at the time services are rendered. Co-payments, deductibles, and coinsurance are due at the time of service for Medicare and other Health Care Plans that are accepted by this office. Obtaining proper referrals to this practice is the patient's / guardian's responsibility and if proper referrals are not obtained, the patient / guardian is responsible for payment in full for services rendered. Charges for patients with insurance plans we do not participate with are due and payable in full at time of service. The patient / guardian is responsible for all fees, regardless of insurance coverage. Motor Vehicle claims are the patient's / guardian's responsibility. Checks returned by the bank will incur an additional $25.00 service fee. I have read the above and request that all payments by my insurance carrier, including Medicare, be paid directly to Action Chiropractic, LLC. I also authorize the release of any medical or other information to my insurance carrier necessary to process my claims. **The signature below acknowledges that I have received a copy of Action Chiropractic's privacy policy. I have read and understand its contents and agree to abide by the terms and conditions therein.**

Signature of patient / guardian____ **Date:**_____________________