Patient Information Sheet

Southpark Chiropractic Wellness Center

1529 46th Avenue, Suite 4, Moline, IL 61265

Personal Information

Name: _____ Date: _____

Address: _____ City, State, Zip: _____

Phone No: _____ E-mail:_____

Birth Date: _____ Age: _____ Social Security No: _____

Employer: _____ Business Phone: _____

Business Address: _____ City, State, Zip: _____

Type of Work: _____ Whom may we thank for referring you? _____

Highest Level of Education: _____

Preferred contact Phone Number at which we may leave a message: _____

___ Single ____ Married ___ Legally separated ___Widowed ___ Divorced

Spouse Name: _____ Employer: _____ Business Phone: _____

Medical Doctor: _____ Last Visit: _____

In Case of Emergency, Notify: _____ Phone: _____

____ Please check here if no insurance

Insurance

Primary Insurance: _____

Name of Insured: _____

Insured's Birth Date: _____

Insured's Social Security No: _____

I hereby give permission to the doctor to release any information to my insurance companies that he deems necessary, or if requested by my insurance companies acquired in the course of my examination and treatment. I authorize my doctor to act as my agent in obtaining payments from my insurance companies.

I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for any non-covered items and/or services. Collection of unpaid balances past 30 days will necessitate a 2.5% per month late fee.

I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and/ or treatment of my condition. I permit a copy of this authorization to be used in place of the original.

Signature_____ Date_____