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Lafayette, LA 70503
(337) 350-0225

CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT

PATIENT INFORMATION: PATIENT NUMBER:_____ DATE: _____
(ASSIGNED BY OFFICE STAFF)

NAME _____ DATE OF BIRTH ___/___/_____ AGE____

MALE ⬭ FEMALE ⬭ SSN ____-___-_____ MARITAL STATUS (S/M/W/D): _____

RACE: (Circle) White - Native American – African American -Asian -American Indian/Alaska Native -Other

ETHNIC GROUP: Hispanic Non-Hispanic Unknown RELIGION: _____ **Declined *please initial*** _____

DRIVERS LICENSE/ ID NUMBER AND STATE OF ISSUANCE _____

ADDRESS_____ APT# _____

CITY_____ STATE_____ ZIP CODE _____-_____

HOME PHONE: (____)_____-_____ CELL: (____)_____-_____ WORK: (____)_____-_____

EMAIL ADDRESS: _____

EMPLOYER'S NAME: _____ OCCUPATION_____

EMERGENCY CONTACT: _____ PHONE _____

HOW DID YOU HEAR ABOUT US? _____

PRIMARY REASON FOR VISIT _____

DATE OF INJURY _____

DATE SYMPTOMS BEGAN _____

IF DUE TO AUTO OR WORK INJURY PLEASE FILL OUT ADDITIONAL "ACCIDENT/WORK INJURY" FORM

HAVE YOU EVER BEEN TREATED BY A CHIROPRACTOR IN THE PAST? YES NO

HAVE YOU SEEN ANY OTHER PHYSICIANS, PHYSICAL THERAPISTS, CHIROPRACTORS OR OTHER CLINICIANS FOR TREATMENT OF THIS CONDITION?

◯ YES ◯ NO IF YES, PLEASE PROVIDE PROVIDER NAME AND DATE RANGE OF TREATMENT

PROVIDER NAME_____TREATMENT DATE RANGE_____

HAVE ANY X-RAYS, MRI, OR CT SCANS BEEN COMPLETED RELATED TO THIS AREA OF INJURY?

◯ YES ◯ NO IF YES, PLEASE SPECIFY NAME OF FACILITY WHERE THESE RECORDS ARE LOCATED

_____

CLAIM INFORMATION: (Complete if Attorney, Employer, or Auto Insurance Is Involved)

IS YOUR CONDITION DUE TO: ◯ AUTO ACCIDENT ◯ PERSONAL INJURY ◯ WORK INJURY

OTHER◯ IF OTHER, PLEASE EXPLAIN: _____

TYPE OF CLAIM ◯ ATTORNEY ◯ WORKER'S COMP ◯ Other

INSURANCE INFORMATION: (Complete if Personal Health Insurance is being Utilized)

RELATIONSHIP TO INSURED ◯ SELF ◯ SPOUSE ◯ CHILD ◯ OTHER _____

NAME OF PRIMARY INSURED _____ DATE OF BIRTH ___/___/____

INSURED'S SSN AND DATE OF BIRTH- SAME AS ABOVE ◯ SSN ___-__-____ DATE OF BIRTH ___/___/____

INSURED'S EMPLOYER - SAME AS ABOVE ◯ _____

PRIMARY INSURANCE CO. _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE_____ PHONE (___) _____

POLICY NUMBER_____ GROUP NUMBER _____

SECONDARY INSURANCE CO. _____ADDRESS _____

CITY _____ STATE _____ ZIP CODE_____ PHONE (___) _____

POLICY NUMBER_____ GROUP NUMBER _____

I WILL BE PAYING TODAY BY: ⬭ CASH ⬭ CHECK ⬭ CREDIT/DEBIT CARD (TYPE_____)

OTHER ⬭ IF OTHER, PLEASE EXPLAIN: _____

AUTHORIZATIONS:

- I attest that the above information is true and correct to the best of my knowledge.
- I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment.
- I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owed to this office by my attorney, out of proceeds of any settlement of my case and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered.
- I understand and agree that health and accident 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 making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to 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 products or professional services rendered will be immediately due and payable.

Patient's Signature _____ Date _____

Guardian Signature _____ Date _____

Office Staff Signature _____ Date _____