Sorrento Valley Chiropractic
Confidential Patient Information

Name_____Date_____

Address_____
City _____State_____ Zip Code_____

Cell #_(_____)_____ E-mail_____
Is it okay to text? (Appointment reminders only) Yes_____
No_____
Cell Phone provider (for Text Messages) ___ATT ___Verizon___Other_____
Birth Date_____ Sex (M / F) Age____
Employer_____Occupation_____
Phone_____Address_____
City_____ State_____ Zip Code_____

Spouse/Significant Other Name_____ Occupation_____
Marital Status M S W D O Number of children_____ Ages___ ____ ____ ____ ___
Emergency Contact_____ Phone_____
Primary purpose of today's visit_____
_____
Similar symptoms (Y / N) Date_____ Other doctors seen for this condition_____
Primary care Physicians name_____
Have you received chiropractic care in the past?_____ Date of last visit_____

This visit is a result of _____Auto Accident_____ Work Injury_____ Chronic problem_____Non-work related injury _____Unknown Origin
Whom may we thank for referring you?_____

Insurance Company_____ Policy #_____Group#_____
Policy Holder _____
Relationship_____
Address_____
Do you have a deductible_____ How much is met_____

Secondary Insurance/HRA/HSA Plan_____

I UNDERSTAND AND AGREE THAT HEALTH AND ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. I UNDERSTAND THAT SORRENTO VALLEY CHIROPRACTIC WILL PREPARE ANY NECESSARY PEPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO SORRENTO VALLEY 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 TERMINTATE MY CARE AND TREATMENT, ALL FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE.

Signature_____ Date_____