Confidential Patient Information

The following information is needed in order to better serve you. Please complete all questions. If you need any assistance, please do not hesitate to ask office staff.

Please print!

Today's Date: / / Name:____

Address:____

City, State, Zip:____________________________Email:______________________________

Can we sign you up for email reminders for future appointments? **Yes / No** Last 4 of SSN:_________

Marital Status: M S W D Age:_____ Birth Date: / / Height: _____ Weight _____

Cell Phone:___________________ Home / Work Phone (circle one):_____________________

Can we sign you up for text reminders for future appointments? **Yes / No**

Occupation:_________________________ Employer:______________________________

Medical Insurance Provider:_________________ ID #:______________________________

Do you have any alternate insurance?: **Yes / No** Are you the insurance policy holder? **Yes / No**

If no, please provide the name and date of birth of the policy holder to office staff.

Is your condition due to an accident? **Yes / No** Date of Accident: / /

Type of accident?: **Auto / Work** Do you have an attorney involved in your injury? **Yes / No**

Were you referred? If yes, by who?:____

By signing this document, you agree that all information above is accurate and up to date. You agree to pay for all services rendered to the above mentioned patient *as the charges incur*. You agree that you will be personally responsible for *all* services performed that are *not covered* by your medical/accident insurance provider. **You agree that if you suspend or terminate your treatment, any fees or services rendered are immediately due and payable to Gottlieb Chiropractic.**

Patient’s Name (Printed):____

Patient/Guardian Signature:____