

WELCOME TO ALABAMA CHIROPRACTIC & SPINE CARE

Please complete the ENTIRE form.

TODAY'S DATE: _____

MR. _____
MRS. (FIRST) _____ (LAST) _____ (MI) _____
MS. _____
MISS ADDRESS _____
DR. _____

(CITY) (STATE) (ZIP)

DATE OF BIRTH: _____ SEX: M / F AGE: _____

RACE/ETHNICITY: HISPANIC BLACK WHITE NATIVEAMERICAN/ALASKA NATIVE
ASIAN/PACIFIC ISLANDER OTHER _____

HOME: () _____ - _____ MARITAL STATUS: S M W D

CELL: () _____ - _____ EMPLOYED: FULL ___ PART ___ N/A ___

WORK: () _____ - _____ STUDENT: FULL ___ PART ___ N/A/ ___

EMAIL: _____

SOC. SEC. #: _____ - _____ - _____ DL#: _____ ISSUING STATE _____

PLACE OF EMPLOYMENT: _____

ADDRESS OF EMPLOYMENT: _____

INSUREDS NAME: _____ INSUREDS DOB _____

INSUREDS EMPLOYER: _____ PHONE #: _____

SECONDARY INSURED'S NAME: _____ SEC. INS. DOB: _____

PERSON RESPONSIBLE FOR BILL: _____

RELATIONSHIP: _____

ADDRESS: _____

IN CASE OF AN EMERGENCY NOTIFY: _____

PHONE: _____ RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

ALL NUMBERS PROVIDED TO US INCLUDING EMERGENCY CONTACT CAN AND WILL BE USED FOR ALL PAYMENT COLLECTION PURPOSES IF NEEDED.

_____ PATIENT'S SIGNATURE