WELCOME To Our Practice. Please complete this form entirely to the best of your knowledge

Patient's Name: ____ Date of Birth: _____/_____/_______ Age: ______

What do you prefer to be called: ___________________ SSN _____ -______ - ______ Gender ___M ___F

Address: ____
(Street) (PO Box) (City) (State) (Zip)

Marital Status M S W D Home Phone ___________________ Cell Phone _______________________
Email ____
Your occupation _____________________ Employer _______________________ Work _________________
Spouses Name _______________________Employer _______________________ Work # ________________

Guardian Information: (complete if under 18)

Mother's name _____________________________
Address ___________________________________
Phone # Home ______________Cell____________
SSN _____-____-______DOB____/____/________
Employer __________________ Work #____________

Father's name _____________________________
Address ___________________________________
Phone # Home _______________Cell ____________
SSN _____-____-______ DOB ____/____/_______
Employer __________________ Work # __________

Billing Information (if different from patient)

Name of person financially responsible for account ____
Relationship to patient __________________________ SSN ______-______-______ DOB ____/_____/____
Address ____
(Street) (City) (State) (Zip)
Phone # Home _____________________ Cell _______________________ Work ______________________

Insurance

Insured by ____Self ____Spouse ____Father ____ Mother ____ Grandparent ____ Other _________________
Primary Insurance Co ____________________________ Policy Holder_______________________________
SSN _____-_____-_____ DOB ____/____/____ ID #_______________________________________
Address ____
(Street) (City) (State) (Zip)
Phone # Home ___________________________________ Cell ______________________________________
Secondary Insurance Co ____________________________ Policy Holder____________________________
SSN _____-_____-_____ DOB ____/____/____ ID #_______________________________________

Are your present symptoms or condition related to, or the result of an auto collision, work-related injury or other personal injury? _____ Yes _____ No

I do hereby authorize the release of any medical information necessary to process all claims, and request payment of any medical benefit be paid to Foster Family Chiropractic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

X ____ ____
Signature of patient or patient representative **Relationship of patient representative to patient**

____
(Date)

For Office Use **File #**____________
Welcome to the office ____ **Next Welcome Form Due** _____________ **Entered in System** _______