Pacific Chiropractic Clinic

Date_____

Patient Name_____ Birthdate_____

Address_____ Sex M F Age_____

City_____ State_____ Zip_____

Phone ( )_____ Work Phone ( )_____

Occupation_____ Employer_____

Spouse Name_____

Health Plan_____

Subscriber_____ Subscriber Birthdate_____

ID#_____ Group #_____

Primary care Physician Name_____

Accompanied by_____

Minors-Parent's Name (& address if different)_____

_____

I understand and agree that Health and Accident Insurance policies are an arrangement between an Insurance Carrier and myself. Furthermore, I understand that this Chiropractic 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 on 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.

Signature _____

(IF PATIENT IS A MINOR - PARENT OR GUARDIAN MUST SIGN)

Robert Hollingsworth, D.C.
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