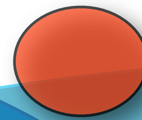
BLUE MOUNTAIN CHIROPRACTIC



HEALTHY SPINE, HEALTHY BODY

Patient Application

Name_________________________________Phone_________________________

Cell___________________________________Email_________________________

Address,City,State,Zip____

Birth Date___________Age__________( )Male ( )Female # of Children____________

( ) Married ( )Single ( )Divorced ( )Widowed; Occupation_________________________

Employed by________________________ Work Address_______________________

How were you referred to our office?____

Have you ever had chiropractic care before?___________If yes, when?___________

List your chief complaints in order of severity:

1.______________________________________ For how long?________________

2.______________________________________ For how long?________________

3.______________________________________ For how long?________________

Who is your family doctor? __________________ Address_______________________

May we consult with him/her in regard to your care? ( ) Yes ( ) No

Is this injury or illness related to an auto accident?_________(If yes, name YOUR:)

Auto Insurance Co.____________________Policy #___________________________

Claim#________________________Phone#_________________________________

If you have health insurance please allow us to make a copy of your health insurance card so that we may make a copy in order to file your claim on your behalf as a courtesy to you. Will you authorize us to file your health insurance claim on your behalf? ( ) Yes ( ) No ( ) Does not apply

Notice: We receive payment upon time of the service rendered. As a courtesy to our patients we file their health insurance claims on their behalf. Health insurance is a contract between you and your health insurance company. We gladly file your health claim on your behalf so that you will be reimbursed based upon the contracted policy between you and your health insurance company.

Patient's Signature____