

SUMMERVILLE CHIROPRACTIC, LLC 1357 Bacons Bridge Rd. Summerville, SC 29485

CONFIDENTIAL PATIENT INFORMATION

PATIENT # _____
DATE _____

Name _____ Home/Cell Phone _____ / _____

Address _____ City _____ ST _____ Zip _____

Age _____ Birth Date _____ Marital Status: M S W D Email _____

Occupation _____ Employer _____

Emp. Address _____ Work Phone _____

Spouse's Name _____ Birthdate _____ Occupation _____

Employer _____ Work Phone _____

Patient's Nearest Relative _____ Phone # _____

Referred By _____

Purpose of This Appointment _____

Other Doctors Seen For This Condition _____

Have You Been Treated For Any Health Condition In The Last Year? Yes: () No: ()

If Yes, Describe: _____

What Medications Are You Taking _____

PAYMENT IS EXPECTED AT THE TIME OF SERVICE

There will be a carrying charge of 1.5% per month, 18% per year added to any past due accounts.

Name of person responsible for payment _____

ARE YOU INSURED? () YES () NO If yes, Name of Company _____

I understand and agree that all accident and health insurance policies that I may have are an arrangement between the insurance carrier and myself. I understand that Summerville Chiropractic, LLC will prepare the necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Summerville Chiropractic, LLC will be credited to my account. I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment at this facility, all fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ SS# _____ Date _____

Parent or Guardian Signature Authorizing Care _____ Date _____

Information Taken By _____ Date _____

