MORRIS FAMILY CHIROPRACTIC

PATIENT INFORMATION

****ALL PATIENTS UNDER 18 YEARS OF AGE MUST HAVE A LEGAL GUARDIAN WITH HIM/HER AT EVERY APPOINTMENT****

Date:_____

Last Name: _____ First: _____ MI:_____ Nickname: _____

Patient Address: _____ Apt # _____

City: _____ State _____ Zip _____

Cell Phone: _____ Home/Alternate Phone # _____

Email address: _____ Last 4 digits SS#_____

Sex:_____ Date of Birth: _____ Marital Status: M☐S☐D☐W☐

Race/Ethnicity (circle): White (Non-Hispanic) ☐ White Hispanic ☐ Black/African American☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander☐ Decline to Answer☐

Military Member (active or former/retired)? _____

Are you: Disabled☐ Retired☐ Student☐

Name of Employer:_____

How did you hear about us (friend/internet/doctor, etc)?_____

Emergency Contact:

Name: _____ Phone: _____ Relation:_____

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Are you here because of an injury/accident <u>involving an auto or worker's comp claim</u>?

If YES, PLEASE INFORM RECEPTION IMMEDIATELY.

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ALL PATIENTS: PLEASE READ AND SIGN THE FOLLOWING:

I attest that the above information, to the best of my knowledge, is accurate and true. I will provide the clinic updates as information changes.

Assignment of Benefits:

I hereby assign the benefits under my insurance policy or policies and carrier(s), not to exceed the provider's charges, to Joseph E. Morris DC, LLC (Dr. Morris, DBA Morris Family Chiropractic). I authorize and direct that my insurer make payment to Joseph E. Morris DC, LLC (Dr. Morris, DBA Morris Family Chiropractic). I also authorize Joseph E. Morris DC, LLC (Dr. Morris, DBA Morris Family Chiropractic) to release any information or records necessary to process my claim. I understand that I am financially responsible to pay for all charges* **<u>whether covered by insurance, or not</u>**. *All charges will be at insurance negotiated rates.

Patient/Guardian Signature _____ Date _____