Sitzmann Chiropractic, LLC (864) 458-8888 Greenville, SC

Patient Information Sheet

SSN_____ Last Name_____ First Name_____ MI___

Gender ____M ____F D. O. B. ___/___/____ Marital Status ____S ___M ___D ___W

How did you hear about our office?_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Email_____

Language ___English ___Spanish ____Other:_____

Employer Name_____ Address_____

Work Phone_____ Employment Status ___Full ___Part ____Retired ___Disabled

Emergency Contact Information:

Name_____ Phone_____ Relationship_____

Primary Insurance

Insurance:_____
Policy Number_____
Group Number_____
Insured Name*_____
Relation to Patient_____
Insured D.O.B.*_____

Secondary Insurance

Insurance_____
Policy Number_____
Group Number_____
Insured Name*_____
Relation to Patient_____
Insured D.O.B.*_____

*If your insurance is in another family member's name the above fields would be that family member's information

RELEASE OF INFORMATION AND PATIENT CONSENT

I authorize Sitzmann Chiropractic LLC to release any information acquired in the course of my medical examination and treatment. I authorize all information to be released to my insurance company, third party payers, case utilization, managed care review companies, Health Care Financing Administration. I further authorize information to be released to all other Sitzmann Chiropractic LLC affiliated institutions or individuals who will be providing healthcare services to me.

I hereby authorize Sitzmann Chiropractic's staff to give the following people information concerning my test results, health status, appointment times, and procedure information. Name_____

FINANCIAL AGREEMENT

INSURANCE : I understand and agree that health insurance policies are an arrangement between my insurance carrier and myself. I understand that Sitzmann Chiropractic will file all primary insurance claims for me. I authorize payment of medical benefits directly to Sitzmann Chiropractic, LLC. Furthermore, I agree that if my insurance does not pay for my claim(s), it will become my responsibility.

SELF PAY : We request full payment at the time treatment was rendered. *To financially assist you and your family members, we offer pre-pay, wellness, student, and child plans*. We are happy to accept cash, check, or credit card.

**Name_____ Signature(Guardian)_____ Date_____