YOUKER CHIROPRACTIC and MASSAGE

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Bradenton, Florida 34208
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CONFIDENTIAL PATIENT INFORMATION

Name: ______________________________ Date: __________

Address: ______________________________

City/Town: ______________________ State: __________ Zip: __________

Sex: M / F Age: ________ Date Of Birth: __________ Height: ________ Weight: ________

Home Phone: (____)__________ Cell Phone: (____)__________ Work Phone: (____)__________

E-Mail Address: ______________________ S.S. #: ______________

Occupation: ____________________ Employer: ____________________

Marital Status: S / M / W / D Number of Children: __________ Is the patient a minor? YES / NO

Spouse's Name: ____________________ Employer: ____________________

Emergency Contact: ______________ Phone: (____)__________ Relationship: __________

Method Of Payment: (Circle One) Cash/Check Credit/Debit Card Health Insurance Auto Insurance Workers' Comp.

ACCIDENT INFORMATION

Is Your Condition Due To An Accident? YES / NO Type Of Accident: AUTO / WORK / OTHER __________

Date Of Accident: ______ Date Symptoms First Appeared: ______ Days Lost From Work: From: ______To: ______

Do you have an Attorney?____________________ Phone #:______________

INSURANCE INFORMATION

Insured's Name: ______________ Relation To Insured: SELF / SPOUSE / CHILD / OTHER ______

Ins. Co. Name: ______________ Policy #: ______________ Group #: __________

Claim # (If Accident): ______________ Adjustor Name: __________ Phone: (____)__________

Address: ______________________ City: ______________ State: _____ Zip: ________

Payment is due at the time service is rendered, unless prior arrangements have been made. I understand that I am personally responsible for payment of all services rendered to me, and agree that health and accident insurance policies are an arrangement between my insurance company and myself—NOT between my insurance company and this office. I authorize *YOUKER CHIROPRACTIC & MASSAGE* to release any medical information and to complete any usual and customary reports and forms to assist in collecting from my insurance company. I know that I am responsible for my deductible, co-pays and any percentage that my insurance company does not pay for. Additionally, if the patient is a minor, I authorize treatment.

Signature: (Patient, Parent, Legal Guardian or Responsible Party)

I Request Services: **X** ______________________________ Date: __________