POMPANO BEACH
CHIROPRACTIC CLINIC, P.A.

Family practice since 1951!

4 NE 4th Avenue
Pompano Beach, FL 33060
(954) 943-1044 office
(954) 943-1014 fax
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PATIENT INFORMATION

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Name: ______________________________________ Home Phone: ___________________ Cell Phone: ___________________

Address: ____ City: _____________________________State: _____ Zip:_________

Age: ________ Birth Date: ____/____/_______ Gender: **M F** Martial Status: **S M W D Sep** No. Children: _____________

Email: ____________________________ SS#: ____/____/_____ Emergency Contact/Phone: ____________________________

Your Employer: _______________________________________ Occupation: ______________________ Years on Job: _______

Work Phone: ________________________ Insurance Company: ____

Subscriber's Name: _________________________________ Birth Date: ____/____/______

Patient's relationship to subscriber: O Self O Spouse O Child O Other Secondary Insurance: _______________________

Name of Spouse, Parent or Guardian: ____________________________________ Age: _____ Birth Date: ____/____/________

Does your spouse have insurance at work? O YES O NO Insurance Company: _____________________________________

How did you find out about our office? ____

Describe the major complaints that bring you to our office: ____

Is your condition due to an accident? O YES O NO Date of accident: ____/____/_________

Primary Care Physician: ____

Have you ever been to a Chiropractor before? O Yes O No If yes, who and when was last visit: __________________________

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. If the doctor is a contracted provider for my insurance, I understand I am responsible for all co-payments and non-covered services. I also understand and agree to pay all co-pays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

Patient's Signature: ____ Date: ________________________

Parent or Guardian's Signature: ____ Date: ________________________