



# Scott Chiropractic & Wellness

5080 Virginia Pkwy - STE 550 - McKinney, TX 75071

Phone: (972) 540-5445 • Fax:

## Patient Information

Name: (First, Middle, Last) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ (City, State, Zip): \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Sex:  M  F Marital Status:  Single  Married  Widowed  Divorced  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Maiden Name: \_\_\_\_\_ Employment Status:  Employed  Part-time Student  Full-time Student  Other

## Employment Information

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Address: \_\_\_\_\_ (City, State, Zip): \_\_\_\_\_

## Responsible Party Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ (City, State, Zip): \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Responsible Party's Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

## Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Insured's Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ ID Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ (City, State, Zip): \_\_\_\_\_

## Spouse Information

Name: (First, Middle, Last) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ (City, State, Zip): \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_

## Relative to Contact in Case of Emergency

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
 Address: \_\_\_\_\_ (City, State, Zip): \_\_\_\_\_

## Is Your Illness or Injury Related to Any of the Following?

Employment  Emergency  Accident  Auto Accident (State of Auto Accident) \_\_\_\_\_

If Employment related, has employer been notified?  Yes  No Employer Contact Name: \_\_\_\_\_

Employer Contact Phone and Extension: \_\_\_\_\_

## How Were You Referred to Our Office?

By an Attorney  By a Doctor  By a Patient  Yellow Pages  Other

Please print the name of your source: \_\_\_\_\_

## Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Scott Chiropractic & Wellness all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: \_\_\_\_\_

Date: \_\_\_\_\_