BOYNTON BEACH CHIROPRACTIC
PATIENT INTAKE FORM

File Number:	Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Sex: ☐ M ☐ F	Birth date: / /	Age:	Email address :

Street address:	Social Security no.:	Home/Cell phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

INSURANCE INFORMATION

PCP:	PCP Phone Number: ( )

Insurance Company:	Address:	Phone Number: ( )	Effective date: / /
			DOA: / /

Please indicate primary insurance ❑ PPO ❑ HMO ❑ POS ❑ PIP ❑ WC ❑ MEDICAID ❑ MEDICARE ❑ Other

Subscriber's name:	Subscriber's SSN:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Claim no:

Attorney:	Phone Number: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Boynton beach chiropractic Patient Intake form or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*