

**Patient Information**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Social Security# \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Email : \_\_\_\_\_  
Phone Number(\_\_\_\_) \_\_\_\_\_ Alternate Number(\_\_\_\_) \_\_\_\_\_  
Drivers License Number \_\_\_\_\_ State \_\_\_\_\_  
Employment Status \_\_\_\_\_ Employer \_\_\_\_\_  
If Retired, Please list former employer \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_  
Physician Yellow Pages Staff Insurance Carrier Received Mailing

Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_  
Spouse Employment Status \_\_\_\_\_ Spouse Employer \_\_\_\_\_  
If female, Number of children \_\_\_\_\_

**Insurance Information**

Insurance Carrier Name \_\_\_\_\_  
Insured Name \_\_\_\_\_  
Insured Date of Birth \_\_\_\_\_  
Relationship to Insured Self Spouse Dependent /Child

If you have Medicare, please answer next question.  
To the best of my knowledge, no other insurance is primary to Medicare. True \_\_\_\_\_ False \_\_\_\_\_

**Signature Authorization**

I request that payment of authorized Medicare, Medigap and / or other Insurance Carrier benefits be made on my behalf to Gateway Chiropractic Center, as indicated on this form for any services furnished to me by Gateway Chiropractic Center. I authorize the release of any medical information about me to Health Care Financing Administration and / or insurance(s) and their agents as necessary to process my claim. I also agree to be responsible for any deductions, co- insurance, co-payments or disallowance of payment by my insurers. I understand that some services may not be covered by my insurance(s) and that I am responsible for paying for any uncovered services. I understand that in the event of default of payment, of any amount due by me, that the account will be placed in the hands of a collection agency and / or attorney. I understand that I will be responsible to pay any additional fees as a result of collection activity and/or legal fees. I have read the above information and had any questions that I may have had at the time of signing explained to me.

Signature Of The Patient or Responsible Party \_\_\_\_\_

Do we have your permission to leave a message on answering machine, voicemail? \_\_\_\_\_