**DEMETREE CHIROPRACTIC GROUP**

# NEW PATIENT GENERAL INFORMATION FORM I – GROUP INSURANCE

## WELCOME

Thank you for selecting Demetree Chiropractic Group as part of your healthcare team! We strive to provide our patients with the best health care possible. To help us meet your healthcare needs, please fill out this form completely (in ink). If you have any questions or need assistance, please ask us – we will be happy to help.

## 1 Personal Information

Date_____

Name_____Nickname_____

Birthdate_____ Age____ SS#/SIN_____

__Male __Female __Minor __Single __Married __Divorced __Widowed

Address_____Email_____

City_____State/Prov_____Zip/PC_____

Employer_____Occupation_____

Referred by_____

## 2 Responsible Party

Who is responsible for the account?

Name_____Relationship to Patient_____

Birthdate_____Driver's License #_____

SS#/SIN_____Email_____

Address_____

City_____State/Prov_____Zip/PC_____

Employer_____Occupation_____

Work Phone_____Ext#_____

Home Phone_____Cell Phone_____

## 3 Telephone

Home Phone_____Cell Phone_____

Work Phone_____Ext#_____

Where do you prefer to receive calls? __Home __Work __Cell

When is the best time to reach you? Time_____Days_____

In the event of an emergency, who should we contact?

Name_____Relationship_____Work#_____ Home #_____

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## 4 Group Insurance Information

### Primary Insurance

Name of Insured_____
Relationship to patient_____
Insured's Birthdate_____
SS# / SIN_____
Employer_____
Date Employed_____
Occupation_____

Insurance Company_____
Group #_____
Employee/Cert.#_____
Ins. Co. Address_____
Deductible_____
Amount already used_____
Max. annual benefit_____

### Additional Insurance

Name of Insured_____
Relationship to patient_____
Insured's Birthdate_____
SS# / SIN_____
Employer_____
Date Employed_____
Occupation_____

Insurance Company_____
Group #_____
Employee/Cert.#_____
Ins. Co. Address_____
Deductible_____
Amount already used_____
Max. annual benefit_____

## 5 Authorization and Release

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payors and/or other health practitioners.
- I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____
Signature of patient or parent/guardian if minor Date

## 6 Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option, which you prefer.
Payment in full at each appointment.

_____Cash
_____Personal Check
_____Credit Card___Visa ___MC
_____I wish to discuss the office's payment policy

### Late Charges

If I do not pay the entire new balance within 25 days or the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.