Aragao Family Chiropractic, Inc.

Patient Information

Patient's Name (First, Middle Initial, Last)	Employer
Patient's Address / Mailing Address	Work Address
City State Zip	City State Zip
Home Telephone Cell Phone	Work Telephone (include extension)
SS# (*optional except for VA patients*)	Occupation
Birth date Sex M F	Relationship Status Single Married Domestic Partner Widowed Divorced Separated

****** How did you hear about Aragao Family Chiropractic?**

[ ] My Doctor_____ [ ] Friend/Relative_____ [ ] Yellow Pages [ ] Web Site
[ ] Health Insurance [ ] Sign [ ] Facebook [ ] Yelp
[ ] Google/Yahoo/Bing [ ] Angie's List [ ] Healthgrades.com
[ ] Other_____

Primary Care Physician:_____ Phone number:(_____)_____

Emergency Contact Information

Name:	Relationship:
Address:	Phone Number:

Insurance Information

Primary Insurance Company	Policy Holder's Name
Policy Holder's Date of Birth	Policy Holder's Address

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including medicare, private insurance and other health plans to Aragao Family Chiropractic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Name_____ Date_____