



SEAY CHIROPRACTIC & WELLNESS

GENERAL INFORMATION - Please print

Patient Full Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ Social Security Number _____ Age _____ Gender _____

How would you like to be addressed? _____ Marital Status: Single Married Widowed Divorced

By filling out your email address you are agreeing to receive office newsletters & announcements.

E-Mail Address _____

Employer Name _____ Phone (work) _____

Employer Address _____

Occupation _____ Circle One: Full time Part time Retired Not Employed

Your Emergency Contact Person _____ Relationship _____

Address _____ Phone number _____

Who may we thank for referring you? _____

INSURANCE INFORMATION

Primary Insurance Company Name	Secondary Insurance Company Name
Primary Name on Insurance Policy _____ Policy # _____ Policy Holder's Date of Birth _____ Relation to you _____ Policy Holder's Employer _____	Primary Name on Insurance Policy _____ Policy# _____ Policy Holder's Date of Birth _____ Relation to you _____ Policy Holder's Employer _____

I understand and agree that:

- All visit charges are payable when services are rendered.
- The fee paid for x-rays is for analysis only. The film itself is the property of this office.
- Health and accident insurance policies are an arrangement between my insurance carrier and me.

I authorize payment of benefits to Seay Chiropractic & Wellness Center, as agreed upon at the time of treatment for services rendered.

I also understand that I am financially responsible for all charges and my insurance will be filed if at my request. I certify that the information I give is true and understand that it is completely confidential.

Patient Signature _____ Date _____

Guardian Signature Authorizing Care _____ Date _____