MOORE
CHIROPRACTIC AND
WELLNESS CENTER

936 Roosevelt Trail Windham, ME 04062 • (207) 892-8356

Patient Information

Patient's Name

First Name: ______ MI: ______ Last: ______

Age: ______

Date of Birth: ____/____/____

❑ **Female** ❑ **Male** | ***Marital Status:*** ❑ Married ❑ Single ❑ Partner ❑ Divorced ❑ Widowed

SS#: ______

If the Patient is a Child, enter the Parents Name:

First Name: ______ MI: ______ Last: ______

Driver's License #: ______

Address Information

P.O. Box: ______ City: ______ State: ______ Zip Code: ______

Street: ______ City: ______ State: ______ Zip Code: ______

Home Phone: ______

Cell Phone: ______

Work Phone: ______

Pager #: ______

Employed by: ______

Employer Address: ______

______

Occupation: ______

Information of Responsible Party

Name: ______ Relationship: ______

Address: ______ Telephone: ______

Person to Contact in Case of Emergency

Name: ______ Relationship: ______

Telephone: ______

Family Doctor

Name: ______

Address: ______ Telephone: ______

Referring Doctor or Person

Name: ______

Address: ______ Telephone: ______

Have you obtained the necessary insurance referral? ❑ Yes ❑ No (If No, please contact your Primary Care Physician.)

Have you been treated for this problem before? ❑ Yes ❑ No

If Yes, by whom? ______ and where? ______

Was an X-ray or MRI taken? ❑ Yes ❑ No

If Yes, when? ______ and where? ______

Please complete reverse side

Form # PAT100

Patient Name: ____________________

Insurance Information

(Please bring your insurance card with you at the time of your appointment)

Primary Insurance Company

Company Name: ____________________

Address: ____________________

____

____

Primary Insurance Company (continued):

Policy Owners Name: ____________________

Date of Birth: ____________________

Certificate #: ____________________

Group #: ____________________

Secondary Insurance Company:

Company Name: ____________________

Address: ____________________

____

____

Secondary Insurance Company (continued)

Policy Owners Name: ____________________

Date of Birth: ____________________

Certificate #: ____________________

Group #: ____________________

❑ Medicare	Identification #: ____________________
❑ Medicaid	Identification #: ____________________

For AUTO ACCIDENT CASES ONLY

Auto Insurance Company: ____________________

Address: ____________________

____

Adjuster Name: ____________________

Policy Owners Name: ____________________

Claim #: ____________________

Date of Accident: ____________________

Telephone #: ____________________

If this is a Worker's Compensation Injury please fill out the information below.

Date of Injury: ____________________ Date injury reported to employer: ____________________

Did your employer send you here today? ❑ Yes ❑ No

Employer: ____________________

Address: ____________________ Phone: ____________________

WC Insurance Carrier: ____________________ Claim #: ____________________

Address: ____________________

Adjuster Name: ____________________ Phone: ____________________

Are you currently working? ❑ Yes ❑ No If No, date you last worked: ____________________

Authorization

I understand that even though I may have insurance coverage, I am financially responsible for payment of services.

- I hereby authorize release of medical information for processing insurance claims.
- I hereby authorize payment directly to Moore Chiropractic Center.
- I hereby authorize the release of medical information to physicians and others responsible for my care.

Date: ____________________ Signature: ✗ ____________________

Some medical insurance plans require a referral or pre-certification for treatment. It is your responsibility to follow your insurance company's guidelines for proper reimbursement. If you have questions, our office staff can assist you.