



Welcome to our office! Thank you for choosing us as your chiropractic provider. Please complete the following information.

PATIENT INFORMATION

I am a/an: [] New patient [] Existing patient/providing updated information

Legal name: _____ SSN: _____ Preferred name: _____

Birth date: _____ Age: _____ [] Male [] Female E-mail: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

Employer address: _____ City, State, Zip: _____

Are you: [] Married [] Separated [] Widowed [] Divorced [] Single [] Prefer not to indicate

Health complaints/reasons for consulting this office: _____

Is this due to a: [] Work-related injury [] Vehicle accident/injury

Whom may we thank for referring you? _____

Please indicate whom we could contact in case of an emergency:

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____ Work phone: _____

FINANCIAL INFORMATION

Legal name of person responsible for this account: _____ Relationship to patient: _____

SSN: _____ [] Male [] Female E-mail: _____

Address: _____ City, State, Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Employer: _____ Occupation: _____

Employer address: _____ City, State, Zip: _____

INSURANCE INFORMATION

Legal name of insured: _____ Relationship to patient: _____

Insured's birth date: _____ SSN or Member ID No.: _____ Group No.: _____

Insurance company: _____ Insurance phone: _____

Insured's employer: _____ Work phone: _____

Employer address: _____ City, State, Zip: _____

Please indicate any secondary insurance you have: _____ Please tell me more about this [] Yes [] No

CERTIFICATION AND ASSIGNMENT

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, my minor child, and/or the individual that has appointed me as their legal representative or guardian (hereafter "I"), ever have a change in health, insurance, and or benefits. By signing this form, I certify I have insurance coverage with the above-named insurance company(ies), authorize the use of my signature on all insurance submissions, and assign directly to Daron Halle Chiropractic all insurance benefits payable for services rendered. I also hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical condition(s), accident(s), injury(ies), illness(es), past or future condition, to pay directly to and exclusively in the name of Halle Chiropractic LLC, such sums as may be owing for charges incurred by me for any and all service(s) rendered. Whether or not reimbursed by any or all of these entities, I understand that I am financially responsible for all charges.

Dr. Halle may use my healthcare information and may disclose such information to the above-referenced payers and their agents for the purpose of obtaining payment for services and determining insurance benefits or benefits payable for related services.

Signature of patient, parent, or legal representative/guardian

Date

Printed name of patient, parent, or legal representative/guardian

Relationship to patient