AGUAYO CHIROPRACTIC & Wellness

Dr. Jason P Aguayo DC

Date: ____/____/____ Patient Name: _____ Sex: M F

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Date of Birth: ____/____/____ Age: _____

Circle one: Married /Single/Divorced /Widowed /Separated

Email: _____ Employed? Yes / No

Employer: _____ Occupation: _____

Emergency Contact: _____Relationship: _____ Phone #: _____

How did you hear about our office? Referred by: _____Yellow Pages / Internet / Location

Who is responsible for your bill: you and Spouse/Work Comp/Auto Ins./Medicare

INSURANCE INFORMATION

Primary Insurance Company Name: _____ Health Card #_____

Insured Person's Name: _____ Insured Date of Birth____/____/____

Relationship to Patient: _____ Insured Employer: _____

Secondary Insurance Company Name: _____ Health Card #_____

Insured Person's Name: _____ Insured Date of Birth____/____/____

Relationship to Patient: _____ Insured Employer: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I authorize the release of any medical or other information needed to process this claim and I understand that any amount authorized to be paid shall be paid to **Aguayo Chiropractic & Wellness**, **INC.**, and will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be due immediately and payable.

Patients Signature: _____SS#:_____Date: ____/____/____

Guardian or Spouse's Signature Authorizing Care: _____Date: ____/____/____

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