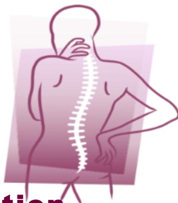

Chugach Chiropractic Clinic LLC

11462 Business Boulevard, Eagle River, Alaska 99577
(907) 694-9224 ◆ Fax: (907) 694-1066
www.careforyourspine.com

Patient Information AUTO ACCIDENT

PLEASE PROVIDE A VALID PICTURE ID TO THE FRONT DESK

SOCIAL SECURITY #: ___________-_____________-_____________

FIRST NAME: __________________________ MIDDLE: __________

LAST NAME: __________________________ SEX: MALE or FEMALE

DATE OF BIRTH: _____/_____/_____ MARITAL STATUS: M S D W

CIRCLE ONE: EMPLOYED STUDENT RETIRED UNEMPLOYED

EMPLOYER/OCCUPATION: _________________________________

EMAIL ADDRESS: ____________________________@____________

DATE OF ACCIDENT: _____/_____/_____

ATTORNEY'S NAME:____

ATTORNEY'S PHONE #: (______)__________-___________________

MAILING ADDRESS: ___________________________________

____

CITY, STATE, ZIP: _____________________________________

PHYSICAL ADDRESS: ___________________________________

CELL PHONE: (_____)_______-_______________________

WORK PHONE: (_____)________-_____________________

HOME PHONE: (_____)_______-_______________________

HOW DID YOU HEAR ABOUT US? (PLEASE CIRCLE ONE)

- -WEBSITE
- -LOCATION
- -FACEBOOK
- -ANOTHER PROVIDER
- -STAFF: ______________________________________
- -EXISTING PATIENT:_____________________________
- -OTHER (PLEASE SPECIFY): _________________________

Auto Insurance Information

INSURANCE COMPANY: ___________________________________

CLAIM NUMBER: ____

POLICY ID NUMBER: _____________________________________

INSURED'S NAME: ___________________________________

ADJUSTER'S NAME: __________________________________

ADJUSTER'S #:(_____)_______-_______________________

Other Party's Insurance Information

INSURANCE COMPANY: __________________________________

CLAIM NUMBER: ____

POLICY ID NUMBER: _____________________________________

INSURED'S NAME: ___________________________________

ADJUSTERS NAME: ___________________________________

ADJUSTER'S #:(_____)_______-_______________________

Emergency Contact

NAME: ______________________________ HOME PHONE #: _____________________ CELL/WORK #: _______________________

Assignment & Release - By *signing below, I authorize Chugach Chiropractic Clinic LLC to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to Chugach Chiropractic Clinic LLC. I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any reasonable collection agency or attorney fees incurred. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

Consent to Treatment *- By signing below, I give my consent for examination and the performance any tests or procedures needed. If patient is a minor, by signing I give consent for examination, tests and procedures for the above minor patient.*

SIGNATURE: ____ **DATE:** _______________________________