

**WINCHESTER HOSPITAL CHIROPRACTIC CENTER
PATIENT INFORMATION**

Name: _____				
First Name	Middle Name	Last Name		
Sex: <u> </u> M <u> </u> F	Date of Birth: _____	SSN _____		
Home Address: _____				
Street	Apt #	City	State	Zip
Home Telephone: _____		Work Telephone: _____		
Marital Status: _____		Employer: _____		

Emergency Contact: _____	
Name	Relationship
Telephone: _____	

PRIMARY INSURANCE	
Name of Insurance Company: _____	
Policy # _____	Group# _____
Subscriber: _____	Relationship: _____
Subscriber's Date of Birth: _____	Subscriber's Employer _____
Date of Injury: _____ (If applicable)	
SECONDARY INSURANCE INFORMATION	
Name of Insurance Company: _____	
Policy # _____	Group# _____
Subscriber: _____	Relationship: _____
Subscriber's Date of Birth: _____	Subscriber's Employer _____

Continue on Reverse Side

CONSENT TO TREAT:

I consent to be treated by the Chiropractor(s) and staff of Winchester Hospital Chiropractic Center.

Sign: _____

Date _____

Patient or Personal Representative

ASSIGNMENT OF INSURANCE BENEFITS:

I request payment of insurance and/or Medicare benefits be made on my behalf to (Corporation).

I understand all copayments are due on the date of service.

I understand I am financially responsible for any treatment or balances not paid by my insurance company.

Sign: _____

Date _____

Patient or Personal Representative

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of Notice of Privacy Practices.

Sign: _____

Date _____

Patient or Personal Representative