Bremen Chiropractic Center PC
CONFIDENTIAL PATIENT INFORMATION

Today's Date _____ Account/Patient Number _____

Mr. Mrs. Ms. (circle one)

Last Name_____ First Name_____ MI _____

Nick Name_____
Note: This is the name you prefer to be called.

Address_____

City_____ State_____ Zip Code_____

Home Telephone_____ Cell Phone _____

Date of Birth _____

Occupation _____

Employer Name_____

Employer Address_____

Employer City _____ State _____ Zip Code _____

Work Telephone_____

Drivers License #_____

Spouse Last Name _____ First Name _____ MI _____

Spouse Date of Birth_____

Spouse Employer _____

Spouse Work # _____

Who referred you to this office?
Name_____ Yellow Pages_____ Website_____

(OVER PLEASE) ---->>

Do you have medical insurance? Yes___ No ___

Do you have a health savings account? Yes___ No ___

Insurance Company _____

If you have made financial arrangements with the receptionist, the following applies:

1) All unpaid balances are due 30 days from date of service.
2) A $4.00 per month service charge will be added to balances after 30 days.
3) Any balance remaining after 90 days will be turned over to legal collection.
4) All Legal and Collection fees are patient's responsibility.

Payment is expected at time of visit, unless other arrangements are requested prior to examination.

I have read and answered the above questions truthfully:

_____
(Patient or Authorized Person's Signature)

BREMEN CHIROPRACTIC CENTER PC
204 E. PLYMOUTH STREET
BREMEN, IN 46506
574-546-4111

I authorize the release of any medical or pertinent information to process my insurance claims. I also authorize payment of medical benefits to the above physician for services rendered.

PATIENT OR AUTHORIZED PERSON'S SIGNATURE:_____

TODAY'S DATE:_____