Foster Family & Sports Chiropractic, LLC **New Patient Personal Information Sheet**

Personal Information

First Name:___________________ Middle Name:__________________ Last Name:_________________

Address:___________________________ City:____________________ State:_________ Zip:_________

Soc Sec #: ____________________ Sex: M F Marital Status: M S W D Sep Age:________

Number of Children:_________________ Your Date Of Birth:______________________

Cell phone number:_______________________ Home Phone number:_______________________

Email Address:_______________________________________

How were you REFERRED to our office? ________________________________

Employment Information

Occupation:______________________Employer:_________________________ Years Employed:_____

Work Phone #____________________ Work Address:____

Primary Care Physician Information:

PCP Name:_____________________________ PCP phone number:______________________________

PCP City and State ____

Insurance Information:

Are you currently covered by health insurance? Please Circle: **Yes** **No** Company: ______________

ID number:_______________________________ Group number:________________________________

Name of primary insured:______________________________ Date of birth:_______________________

Primary insured home address: ____

If you are covered by **Medicare** or if you have **Secondary Insurance** Please circle: **Yes** **No**

Company Name:___________________ ID #_______________________ Group #___________________

Name of person in charge of secondary account: ____

By signing below I certify that the above information is true to the best of my knowledge. I clearly understand and agree that all services are charged directly to me and that 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 to me will be immediately due and payable. Finally, I authorize the release of my medical information relevant to my condition and treatment at this office to any insurance company or doctor as may be needed in the normal course of my care and treatment.

Signature:____ Date:______________________