

PATIENT INFORMATION UPDATE

Date _____

Patient # _____

Name _____

Age _____

Address, City , State & Zip _____

Email Address _____ Phone _____

Work Phone _____ Extension _____

Occupation _____ Employer _____

Insurance Company: _____

Are Your Injuries Due to an On-The-Job Injury? Yes _____ No _____

Do You Plan on Turning it in to Workman's Compensation? Yes _____ No _____

Are You Now or Have You Ever Been Disabled (Service or Work)? Yes _____ No _____

Are You Injuries Due to an Automobile Accident? Yes _____ No _____

Do You Plan on Turning it in to Your Automobile Insurance? Yes _____ No _____

My Present Symptoms Are: _____

Recent Falls: _____

Recent Surgery: _____

Last Adjustment: _____

Since I Last Saw You, I Have Been Seen By Doctor _____

for _____

Patients Comments: _____

It is understood and agreed the amount paid to Palmer Chiropractic Center for X-Ray is for examination only, and the X-Ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. I understand that if my insurance company covers services and the check(s) is sent to the patient, it is the patient's responsibility to bring the check and explanation of benefits to this office. I understand and agree that if my insurance or Medicare fails to provide payment for services rendered that it is my responsibility to pay for these services. Co-pays and/or deductibles that are left unpaid for more than 30 days will incur an 18% interest rate, per month of delinquency.

Patient's Signature