Pike Chiropractic Inc.
Patient Information Questionnaire

Name_____**Birth Date**_____

Home Address Street_____

City_____**State**_____**Zip**_____

Phone#_____**Cell#**_____

E-Mail_____

Marital Status: M S W D, Spouse's Name_____**Number of Children**_____

Who referred you to our office_____

Your Occupation_____**How many years**_____

Employer's name_____

Address_____**Work Phone**_____

Method of Payment: Cash_____**Check**_____**Visa, Master Charge, Discover**_____

Primary Insurance (or present ID card for photo copying)

Name_____**Phone**_____

Address_____
Relation to subscriber_____

ID#_____**Group#**_____

Secondary Insurance Name_____**Phone**_____

Address_____

Relation to subscriber_____

ID#_____**Group#**_____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Pike Chiropractic Inc. will prepare the necessary reports and forms to assist me in making collection from my insurance company and that amount authorized to be paid directly to Pike Chiropractic Inc. will be credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any fee for professional services rendered to me will immediately be due and payable. Also I will be held responsible for any finance charges and/or collection fees.

Patient Signature_____**Date**_____

Guardian or

Spouse Signature_____**Date**_____