WELCOME TO ALABAMA CHIROPRACTIC & SPINE CARE
Please complete the ENTIRE form.

TODAY'S DATE: _____ PREFERRED NAME:_____

MR. _____
MRS. (FIRST) (LAST) (MI)
MS.
MISS ADDRESS _____
DR.

_____
(CITY) (STATE) (ZIP)

DATE OF BIRTH: _____ SEX: M / F AGE: _____

RACE/ETHNICITY: HISPANIC BLACK WHITE NATIVEAMERICAN/ALASKA NATIVE
ASIAN/PACIFIC ISLANDER OTHER_____

HOME: ( ) _____ - _____ MARITAL STATUS: S M W D

CELL: ( ) _____ - _____ EMPLOYED: FULL____ PART ____ N/A____

WORK: ( ) _____ - _____ STUDENT: FULL____ PART ____ N/A/____

EMAIL: _____

SOC. SEC. #: _____ - _____ - _____ DL#: _____ ISSUING STATE_____

PLACE OF EMPLOYMENT: _____

ADDRESS OF EMPLOYMENT: _____

INSUREDS NAME: _____ INSUREDS DOB_____

INSUREDS EMPLOYER: _____ PHONE #: _____

SECONDARY INSURED'S NAME: _____ SEC. INS. DOB: _____

PERSON RESPONSIBLE FOR BILL: _____

RELATIONSHIP: _____ PHONE #:_____

ADDRESS: _____

IN CASE OF AN EMERGENCY NOTIFY: _____

PHONE: _____ RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT OUR OFFICE?
_____

I UNDERSTAND ALL NUMBERS PROVIDED TO ACSC INCLUDING EMERGENCY CONTACT CAN AND WILL BE USED FOR ALL PAYMENT COLLECTION PURPOSES IF NEEDED. I AGREE ALL INFORMATION PROVIDED IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO ENSURE ACSC HAS CORRECT AND UP TO DATE INFORMATION REGARDING INSURANCE PROVIDER(S), ADDRESS, AND PHONE NUMBERS AT ALL TIMES.

_____ PATIENT'S SIGNATURE