Pinnacle Physical Medicine & Rehab/423-855-5053
CONFIDENTIAL PATIENT INFORMATION
PLEASE PRINT

PATIENT INFORMATION: **Date of Birth: _____ AGE _____ SSN: _____**

FULL NAME_____ ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____ EMAIL_____

HOME PHONE_____CELL PHONE_____WORK PHONE_____

Single____ Married____ Divorced___ Widowed____

Which Phone # would be the best one to reach you? Home____ Cell____ Work____ Referred by: _____

WHAT KIND OF MATTRESS DO YOU SLEEP ON? Firm _____ Pillow Top_____ Memory Foam_____ Waterbed_____ Other_____

WHAT POSITION DO YOU SLEEP IN? Side_____ Back_____ Stomach_____

INSURANCE INFORMATION: **(Please give Ins. Card and Driver's License to front desk for copy)**

INSURANCE COMPANY_____ INSURED'S NAME_____

PRIMARY INSURANCE POLICY#_____GROUP#_____

SECONDARY INSURANCE POLICY #_____GROUP#_____

AUTO/WORKERS COMP INSURANCE:

DATE OF ACCIDENT: _____
INSURANCE COMPANY NAME: _____
ADJUSTER: _____
ADDRESS/PHONE: _____
CLAIM #: _____ POLICY #: _____ EFFECTIVE DATE: _____

LEGAL INFORMATION:

ATTORNEY NAME & ADDRESS: _____
_____
ATTORNEY PHONE #: _____

I authorize my insurance company or other coverage to pay directly to, OR, if my current policy prohibits direct payment to doctor, then I hereby instruct and direct you to make check to me and MAIL to the following: Pinnacle Physical Medicine & Rehab, Ted Showalter, D.C, 2605 Jenkins Rd., Suite 2, Chattanooga, TN 37421, (423) 855-5053.
I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself not between me and this office. I authorize this chiropractic clinic to release any medical information and to complete any usual and customary reports and forms at no charge to assist in collecting from my insurance company. I understand that any amount paid to this office will be credited to my account upon receipt. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my schedule of care as determined by my doctor, any fees for professional services will be immediately due and payable. I certify that that I have read and understand this information to the best of my knowledge. The questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient/Guardian Signature: _____ Date: _____