

**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 \_\_\_\_\_                      **REFERRED BY:** \_\_\_\_\_

Which Phone # would be the best one to reach you?    Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

**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. I declare under penalty of perjury (under the laws of the United States of America) that the foregoing is true and correct: I am not attempting to investigate Pinnacle Physical Medicine & Rehab as a representative of any agent or entity, or any insurance company or other organizational entity or person.

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_