WHITE MOUNTAIN CHIROPRACTIC, INC.

Patient Information

PLEASE PRINT CLEARLY!

DATE: _____

LAST NAME: _____ MI: _____ FIRST NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____ WORK: _____

DATE OF BIRTH: _____ SEX: __ M __ F SOCIAL SECURITY #: _____

MARITAL STATUS: __ SINGLE __ MARRIED __ DIVORCED __ SEPARATED; MINOR: __ YES __ NO

EMPLOYER NAME: _____

EMAIL ADDRESS: _____

NAME OF SPOUSE OR OTHER: _____

EMERGENCY CONTACT: _____ PHONE: _____

IS YOUR CONDITION:
EMPLOYMENT RELATED: __ YES __ NO; IF YES, DATE OF INJURY: _____
MOTOR VEHICLE ACCIDENT: __ YES __ NO; IF YES, DATE OF INJURY: _____

IF USING INSURANCE, PLEASE PROVIDE YOUR CARD TO OUR FRONT DESK.

OUR OFFICE NOW KEEPS YOUR VALID CREDIT CARD ON-FILE IN A SAFE AND SECURE SYSTEM THROUGH OUR CREDIT CARD PROCESSING COMPANY (HEARTLAND). YOUR CARD WILL *ONLY* BE USED TO PAY BALANCES DUE ONCE YOUR INSURANCE CLAIMS HAVE BEEN FILED AND RECEIVED. PLEASE PROVIDE THAT AT THE FRONT DESK.
YOU MAY ALSO PAY AS YOU GO IF YOU DO NOT WISH TO LEAVE A CREDIT CARD ON-FILE WITH US.

I authorize the release of any information concerning me or my child's healthcare, advise and treatment provided, for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly, to White Mountain Chiropractic, Inc. or Dr. Bruce Klinekole, DC.

_____ Date: _____
Parent or Guardian Signature of Minor

_____ Date: _____
Patient signature