Paige Chiropractic and Acupuncture

231 Bonnet Street
Manchester, VT 05255

Today's Date: _______________ Referred by: _________________________

Part I: PATIENT INFORMATION

First Name: ___________________________________ Last Name: _________________________

Street Address: ________________________________ Apt #/Floor: ________________________

City/State: ____________________________________ Zip Code: _________________________

Home #: _________________ Work #: ____________________ Cell #: ____________________

DOB: _____________________ Sex (circle): M F SS#: _____________________

Marital Status: ______________ Employer: _________________ Full-time___ Part-Time ___

Student? Y N Full-time___ Part-Time ___ Email: ___________________________

Is patient the primary cardholder for the insurance policy? (please check one):

_____ Yes (skip to PART III) _____ No (if "No", please fill out Part II)

PART II: INSURED'S INFORMATION

Last Name: ________________________ First Name: ________________________

Address: ___________________________ Apt #/Floor: ________________________

City/State: ________________________ Zip Code: __________________________

Home #: _________________ Work #: ___________________ _Cell #: ____________________

DOB: _____________________ Sex (circle): M F SS#: _____________________

Marital Status: ____________ __ Employer: __________________________

What is client's relationship to the insured? (circle one): self spouse child other: _______________

PART III: CLIENT/RESPONSIBLE PARTY AGREEMENT:

* I hereby authorize payment directly to the person providing services for which benefits are payable.

* I hereby authorize the release of pertinent medical information to my insurance carrier.

* I understand that I am financially responsible for all charges for services to me, including the remaining the balance of possible insurance benefits. I will also pay all recovery costs if my account is referred to collections.

Signature: _____________________________________ Print Name: _____________________________________

Relationship to patient: __________________________________