ELITE HEALTHCARE ALLIANCE PATIENT INFORMATION FORM

NAME _____ PHONE# _____
DATE _____

PERSONAL INFORMATION
LEGAL NAME
_____
ADDRESS
_____

CITY/ST _____ ZIP_____

EMAIL ADDRESS _____
HOME PHONE #
_____
WORK PHONE #
_____
CELL PHONE #
_____

DATE OF BIRTH _____AGE _____

___ MALE ___ FEMALE

SS # _____

EMPLOYER
_____
EMPLOYER'S ADDRESS
_____
EMPLOYER'S PHONE
_____

MARITAL STATUS (circle one) M S D W
SPOUSE'S NAME
_____
SPOUSE'S SS #
_____
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?
_____

IN THE EVENT OF AN EMERGENCY
WHO SHOULD WE CONTACT?
NAME
_____
RELATION
_____
HOME PHONE
_____
ALTERNATE PHONE
_____

WELCOME

****

TYPE OF INSURANCE (circle one)
PPO/GROUP - MEDICARE - AUTO – MEDICAID
WORKER'S COMP – CASH

ACCOUNT INFO (if different from patient)
INSURED'S NAME
_____
RELATIONSHIP
_____
BILLING ADDRESS (if different)
_____

CITY/ST _____ ZIP _____

INSURANCE COMPANY:
_____

ADDRESS:
_____

ADJUSTER NAME
_____

WORK PHONE #:
_____

CLAIM #
_____

PERSONAL INJURY

DRIVER'S LICENSE_____
POLICE REPORT _____
CAR INSURANCE _____
MED PAY INSURANCE____

MAJOR MED

DRIVER'S LICENSE___
INSURANCE CARD____
SEC INS CARD _____

CONSENT TO TREAT A MINOR
I HEREBY AUTHORIZE DR. CLAY TO ADMINISTER CHIROPRACTIC CARE AS WELL AS ANY THERAPIES DEEMED NECESSARY TO MY CHILD OR GUARDIANSHIP.

CHILD'S NAME

_____

SIGNATURE (PARENT OR GUARDIAN)

_____ DATE_____

EHA OFFICE POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE MANAGER.
I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM IS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I HEREBY CONSENT TO TREATMENT.

SIGNATURE _____ DATE _____