Primary Elite Chiropractic

1301 Shiloh Rd. NW, Suite #510, Kennesaw, GA 30144 • 678.252.9211
primaryelitechiropractic@gmail.com • www.primaryelitechiropractic.com

Patient Information Form

Patient Name: (Last) _____(First)_____(MI)_____

Name you prefer to be called: _____

Patient Address: _____

City: _____State: _____ Zip: _____

Home Phone: _____Work/Cellular: _____

Date of Birth: _____Age _____ Sex: M F

Email Address: _____

Do you have health insurance? Yes or No Name of Insurance: _____

Employment Information:

Patient Employer:_____ Occupation: _____

Employer Address: _____

City: _____ State: _____Zip: _____

Work Phone No: _____Ext. _____

In Case of Emergency:

Name: _____ Relationship: _____Phone: _____

Patient's Spouse: _____Phone: _____

Family Physician: _____Phone: _____

Referred by: _____

Financial Policy:

Thank you for selecting Primary Elite Chiropractic for your healthcare needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, American Express, Discover, and Cash.

Your Health is our PRIORITY!!

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I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE CHIROPRACTIC PRACTICE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and signature on all insurance claims, including electronic submissions.

I have read and understand all of the above and have agreed to these statements.

Patient Signature _____ Date: _____

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