Mankato Chiropractic Center 31 Navaho Ave, Mankato, MN 56001
507-345-4035

Mankato Chiropractic & Mankato's Healing Touch

PLEASE PRINT ALL INFORMATION **DATE**: _____ Dr. _____

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

ADDRESS: _____

CITY: _____ **STATE**: _____ **ZIP**: _____

HOME PHONE: (_____)_____ **CELL PHONE**:(_____)_____

BIRTH DATE: ____/____/____ **AGE**: _____ **SEX**: M or F **MARTIAL STATUS:** M S W D

SOCIAL SECURITY #: _____-_____-_____ **E-mail :** _____

This information will be kept confidential. Check one in each section.

ETHNICITY: __ Hispanic/or Latino __ Not Hispanic or Latino ___ Decline

RACE: ___White ___Asian ___Black/African American ___Hispanic/Latino ___American Indian/Alaska Native __ Native Hawaiian or other Pacific Islander ___Other List_____ ____Decline

PREFERRED LANGUAGE: _____ English _____Other _____Decline

The above information is required as a result of the implementation of electronic health record based on Medicare/Medicaid guidelines.

OCCUPATION: _____**EMPLOYER**: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: (_____)_____ May we contact you at this number?____yes ____no

SPOUSE'S/PARENT'S NAME: _____ Birth Date: _____/_____/_____

NEXT OF KIN (Not living with you): this section needs to be completed if you are a full time student

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____

WORK PHONE: (_____)_____

REFERRED BY: _____

PURPOSE OF THIS APPOINTMENT: _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

DATE OF LAST PHYSICAL EXAMINATION: _____

HAVE YOU BEEN TREATED FOR ANY HEALTH CONDITION BY A PHYSICIAN IN THE LAST YEAR? YES or NO Date: _____

REASON: _____

OVER - ADDITIONAL INFORMATION ON BACK PAGE....

FINANCIALLY RESPONSIBLE PARTY:

NAME: _____

RELATIONSHIP TO PATIENT: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SOCIAL SECURITY #: _____-_____-_____

HOME PHONE: (_____)_____

WORK PHONE: (_____)_____

CO-PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT!

(Unless other arrangements are made)

The following information is necessary to submit claims to your insurance. Failure to give Mankato Chiropractic center the complete information below will activate patient responsibility for services rendered.

Are you Insured? YES or NO Company: _____

Name of Insured:_____

Your relationship to insured:_____ (Spouse, mother, father, child)

Insured's Date of Birth:____/____/_____(cannot process claims without insured's date of birth)

In consideration of services provided, I am agreeing to pay for services provided to me, to my spouse, and to my minor children. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Mankato Chiropractic Center files insurance claims as a courtesy to their patients. You are strongly encouraged to contact your insurance company or legal counsel to determine the likelihood of reimbursement for chiropractic services. We will not become involved in disputes between the patient and their insurance company regarding deductible, co-payment, covered charges, secondary insurance, usual and customary charges, etc. Do not assume under any circumstances that you are relieved of any financial obligations. Furthermore, I understand that, if I wish, Mankato Chiropractic Center will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Mankato Chiropractic Center will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me, to my spouse, and to my minor children are charged directly to us and that we are personally responsible for timely payment. Failure of timely payment on my part of any charges billed to me may result in collection action.

Patient's Signature: _____

Parent's or Guardian's Signature: _____