



PLEASE PRINT ALL INFORMATION DATE: \_\_\_\_\_ Dr. \_\_\_\_\_

NAME: \_\_\_\_\_  
(First Name) (MI) (Last Name)

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ MARTIAL STATUS: M S W D

SOCIAL SECURITY# \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ EMAIL: \_\_\_\_\_

*This information is 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 records based on Medicare/Medicaid guidelines.*

**OCCUPATION:** \_\_\_\_\_ **EMPLOYER:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WORK PHONE: (\_\_\_\_) \_\_\_\_\_ May we contact you at this number?  Yes  No

**FINANCIALLY RESPONSIBLE PARTY:**

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

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.

Insurance 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.

Signatures/Patient: \_\_\_\_\_ Parent or Guardian : \_\_\_\_\_