KOKOMO CHIROPRACTIC, PC

824 BELVEDERE DR.
KOKOMO, IN 46901

First Name: _____ **Last Name:** _____ **MI:** _____

Name you preferred to be called: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Social Security: _____-_____-_____ **Birth Date:** _____ / _____ / _____

Marital Status: Single Married Divorced Widowed **Sex:** M F

Primary Language: _____ **Race:** _____ **Ethnicity:** _____

Home #: (_____)_____-_____ **Cell #:** (_____)_____-_____

Other #: (_____)_____-_____ **Email:** _____

Work Status: Full-Time Part-Time Retired Unemployed **Student Status:** Full-Time Part-Time

Employer: _____ **Work #:** (_____)_____-_____ **Ext:** _____

City: _____ **State:** _____

Referring Doctor: _____ **Office #:** (_____)_____-_____

Emergency Contact

Name: _____ **Relationship to Patient:** _____

Home #: (_____)_____-_____ **Cell #:** (_____)_____-_____

Other #: (_____)_____-_____

Method of Payment for Today's Visit: Cash Personal Check Credit Card
If insurance does not cover 100%

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize **Kokomo Chiropractic, PC** or insurance company to release any information required to process my claims.

_____ _____
Patient/guardian signature **Date**