Deschutes Chiropractic
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# PATIENT INFORMATION

***Have you been in an auto accident within a year?*** _____*Yes* _____*No*

Full Name_____SS#_____

Mailing Address_____

City_____State_____Zip_____

Phone_____Cell_____Email _____

Sex M___F___Age_____Birth Date_____Single _____Married_____Other_____

Employed By_____Occupation_____

Full Business Address_____Business Phone_____

You were referred by_____

Who is your primary Dr?_____Phone_____City_____

Emergency Contact_____Home#_____Work#_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I authorize my insurance company to pay the chiropractor all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the chiropractor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

**Signature**_____**Date**_____

**PAYMENT IS DUE AT THE TIME OF TREATMENT**