

Brooksville Chiropractic Inc.  
813 S. Broad Street  
Brooksville, Fl. 34601  
P:352-799-3433  
F:352-799-3320

Chart# \_\_\_\_\_

**PATIENT INFORMATION**

Full Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address : \_\_\_\_\_

Home Phone: \_\_\_\_\_ Evening/Cell: \_\_\_\_\_

Work Phone: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status: S M W D Sep Spouse Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Are You A Minor Y / N

Are You A Student Y / N

Your Employer: \_\_\_\_\_ Your Occupation: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Spouse Employer: \_\_\_\_\_ Spouse Occupation: \_\_\_\_\_

**Insurance (Please allow our staff to photocopy your health insurance cards)**

Name of Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

Name of Insured if Different from Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Name of Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_

**Please Tell Us How You Where Referred Here:** \_\_\_\_\_

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- There will be a \$25.00 charge for any Returned/NSF checks and missed appointments.
- We utilize Capital Accounts for any Delinquencies.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse / Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Authorization expires 3 years from date above)