Patient Information Enlighten Chiropractic & Acupuncture

Patient's Name: _____ ☐ Male ☐ Female
Date of Birth: _____ Age: _____ ☐ Single ☐ Married ☐ Divorce
Street Address _____
City: _____ State: _____ Zip code: _____
Occupation: _____ Name of Employer/School _____
Email address: _____
Best number to reach you at:
Home#: _____ Cell# : _____
In case of emergency, contact:
Name: _____ Phone#: _____Relationship: _____

Accident Information:
Is condition due to an accident? ☐ Yes ☐ No
Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other: _____
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Home Insurance ☐ Employer ☐ Worker's Comp ☐ Other: _____
Claim#: _____
Adjustor's Name: _____ Adjustor's Contact #: _____
Attorney's Name: _____ Attorney's Contact #: _____

Insurance
Primary
☐ Self Pay ☐ Medicare ☐ Blue Cross Blue Shields ☐ United Healthcare ☐ Cigna

☐ Other _____
Relationship to insured? ☐ self ☐ spouse ☐ dependant ☐ other
Name of Insured (first,midlle,last) _____
Address: _____ City: _____State _____
Date of birth _____ ☐ male ☐ female SS#_____
Member # _____ Group# _____
Customer Service #_____

Assignment & Release of Information

I certify that I, and/or my dependant have insurance coverage with _____
(Name of insurance Company)
And assign directly to Dr. Vandara Mounarath D.C. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____ _____
Signature of patient/guardian Please print name of patient/guardian Date