

Information/Application for Care

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the office manager.

Name _____ Phone (Hm) _____ (Wk) _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status S M W D No. of Children _____

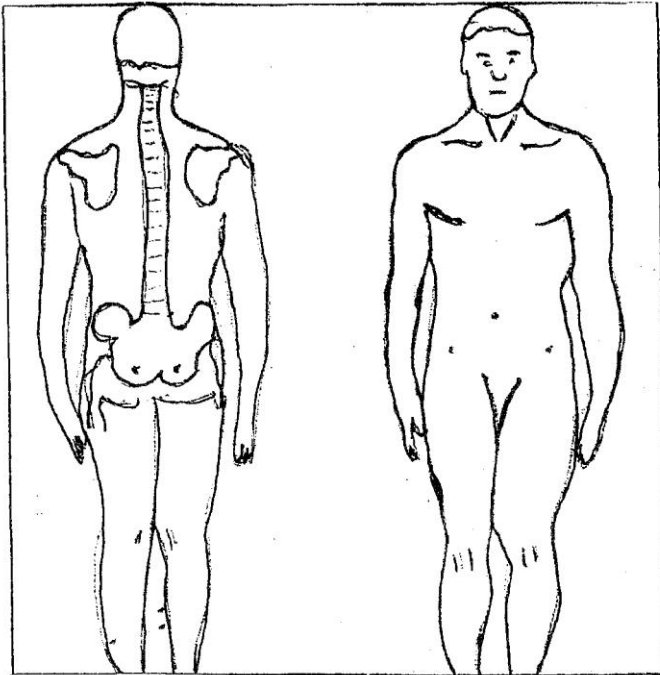
Your employer _____ Occupation _____ Years on job _____

Name of Insured _____ Insured Employer _____

Insured birthdate _____ Do you have Medicare? _____

** If you have insurance and would like us to prepare the forms you need to send for reimbursement please give the office manager your card to copy.

How did you hear about Redmond Spinal Care? _____



Please locate your discomfort/pain on the diagrams to the left. Describe the nature and frequency of your pain/discomfort:

How will payment be made? Cash ___ Check ___ Visa/MC ___

Is your condition due to an auto or work accident? Yes ___ No ___

If yes, date of accident? _____

Have you ever been in an auto accident? Yes ___ No ___ When? _____

I agree to pay for services rendered to the above mentioned patient as the charge is incurred. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and me and that I am responsible for payment of any and all services covered or not covered. I also understand that if I suspend or terminate my care for any reason, any fee for professional services rendered me will be immediately due and payable.

Patient/Guardian Signature _____ Date _____

Note: Full payment for services rendered is due at the end of each visit. If for any reason this request cannot be met arrangements should be made in advance before seeing the doctor. Thank you.