SYNERGY REHAB & CHIROPRACTIC, LLC
NEW PATIENT INTAKE FORM

DATE:_____

NAME:_____DOB:_____/_____/_____

ADDRESS:_____

CITY_____STATE_____ZIP_____

HOME PHONE #_____CELL #_____WORK#_____

EMAIL:_____SEX: M F

EMERGENCY CONTACT:_____RELATIONSHIP:_____

PHONE_____CELL PHONE:_____

MARRIED *DIVORCED* SEPARATED *SINGLE* WIDOWED *MINOR* PARTNERED

OCCUPATION:_____

EMPLOYER/SCHOOL:_____

EMP/SCHOOL ADDRESS:_____

_____EMP/SCHOOL PHONE:_____

HOW DID YOU HEAR ABOUT US?_____

INSURANCE

INSURANCE CO:_____ID#_____

NAME OF POLICY HOLDER:_____

POLICY HOLDER'S DOB:_____/_____/_____ RELATIONSHIP TO PT:_____

IS PATIENT COVERED BY ADDITIONAL INSURANCE: YES NO

IF YES: NAME OF INSURANCE CO_____

POLICY #:_____POLICY HOLDER'S NAME:_____

I certify that I, and/or my dependent(s), have insurance coverage as listed above and assign directly to Synergy Rehab and Chiropractic, LLC 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 for by insurance. I authorize the use of my signature on all insurance submissions. Synergy may use my health care information and may disclose such information to the above mentioned insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

_____ _____ _____

Signature of patient, parent or guardian **Printed name** **DATE**