BACKCOUNTRY CHIROPRACTIC
1354 NW GALVESTON AVE ◆ BEND OR 97701
(541) 385-5900 ◆ Fax (541) 385-6900

PATIENT INFORMATION

Patient's Name____Date_____________________

Address________________________________City__________________State______Zip__________

Telephone_____________________Email ___________________Social Security #______-_____-________

Date of Birth_____/_____/_____ Age__________ Gender: M / F Marital Status: M / S / D

Occupation_______________________Employer ____________________________Years Employed_______

Address _______________________City____________State _____Zip _________ Phone_______________

Spouse's Name_________________ Employer_________________ Family Physician__________________

Emergency Contact Name/Relationship____________________________________Phone_________________

Whom may we thank for referring you to us?____

INSURANCE INFORMATION (please present insurance cards for all coverage)

Insured's Name________________________________ Insured's Date of Birth _____/_____/_____

Insured's Employer____________________________ Insured's Social Security #______-_____-________

Patient's Relationship to Insured: *Self* *Spouse* *Dependent* *Other*___________________________

Do you have Chiropractic Benefits on your plan? *Yes* *No* *Uncertain*

Primary Insurance Company Name ____

Primary Insurance ID #__________________________Primary Insurance Group #_______________________

Primary Insurance Claims Address__________________________________Phone_______________________

ACCIDENT/INJURY/ATTORNEY INFORMATION

Please Indicate Type of Accident: Workers Compensation Motor Vehicle Personal Injury Other

Date of Accident/Injury_____________Time of Accident/Injury___________Claim #_____________________

Patient's Car/Work Comp Insurance Co.__________________________Adjuster/Supervisor________________

Attorney Name_____________________Address____________________________Phone_________________

I hereby affirm the above to be accurate, and consent to chiropractic care in this office.

Patient's Signature ____ Date _______________
(Guardian must sign for all patients 17 years old or younger)