

**EMPIRE HEALTH & WELLNESS CENTER**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_, NY ZIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SEX: M F RELATIONSHIP TO INSURED: Self Spouse Child Other

PATIENT'S EMPLOYER: \_\_\_\_\_ WORK PHONE #: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_ JOB TITLE: \_\_\_\_\_

PATIENT STATUS:  Single  Married  Other  Employed  Student FT  Student PT

EMERGENCY CONTACT: Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

NEXT FOLLOW-UP VISIT DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ FOLLOW-UP NOT SCHEDULED

PRIMARY PHYSICIAN: \_\_\_\_\_

NEXT FOLLOW-UP VISIT DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ FOLLOW-UP NOT SCHEDULED

ARE YOU CURRENTLY BEING SEEN BY A CHIROPRACTOR? Y N

**PRIMARY INSURANCE INFORMATION**

Insurance Carrier: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Insurance Carrier: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<b>Diagnosis:</b> _____ _____ _____ _____
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**IS CONDITION RELATED TO:**

**Employment:** Injury reported to employer? Y N Date of Accident \_\_\_\_\_

Employer at time of accident: \_\_\_\_\_

Name of Comp Carrier \_\_\_\_\_ Phone # \_\_\_\_\_

Claim Number: \_\_\_\_\_ Name of person handling claim \_\_\_\_\_

**Auto Accident** NF application filed with carrier? Y N

Name of Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Adjuster \_\_\_\_\_

Claim/Policy # \_\_\_\_\_

Date of Accident: \_\_\_\_\_ NF application filed with carrier? Y N

Name of policy holder if not patient: \_\_\_\_\_

**Do you have an attorney for either a Worker's Compensation or Motor Vehicle Accident Claim? Y N**

Contact Name/Firm: \_\_\_\_\_ Phone #: \_\_\_\_\_

**I hereby authorize the facility to provide treatment and services to myself and/or above named patient. I also authorize the release of any and all necessary information to my insurance carrier(s) for direct processing by the facility or affiliated agent (or agency) of the facility. Co-payments/insurance, out of pocket expenses & unmet deductibles are expected at time of visit.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_