WELCOME TO OUR OFFICE

TODAY'S DATE ______________________

BACK IN ACTION THERAPY
1011A 10th St.
Alamogordo, NM 88310
(575) 439-9878

Thank you for choosing our office.
In order to serve you properly we will need the following information. (Please print.) Al/ information will be strictly confidential.

Patient's name	Birth date	Marital status Single Married Widowed Divorced

Residence address	City	State	Zip	Home phone

Jf child, parent's name or guardian's name	Email Address

Name of employer	Address	Business phone

Social security number	Occupation

Do you have medical insurance? Yes No	If no, how do you intend to pay? Check Cash Credit card	Ins, co. name & address

Subscriber name	Policy no.	Certificate no.	Is it through your employer? Yes No

Name of spouse	Birth date	Social Security number

Is there secondary ins., spouse 2nd carrier, etc? Yes No	Name & address of spouse employer	Business phone

Secondary ins. name & address	Policy no.	Certificate no.

Medicaid no.	Medicare no.

Workmen's compensation	Name of company

Address of company	Company phone	Treatment authorized by

Person financially responsible for this account	Address	Relationship to Patient

Nearest friend or relative not residing with you	Relationship to patient	Phone

Whom may we thank for referring you?	Address

What is your chief complaint?

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office.

I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

* *I agree with this statement of authorization*

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