Health and Wellness Chiropractic Center P.C.

Healthy Body • Healthy Spine • Healthy Solution

5153 W 120th Ave, Broomfield, Colorado 80020

Name: _____ **Date**:_____

Address: _____**City/State/Zip**: _____

Home Phone: _____ **Work Phone**: _____ **Birth date**: _____

Sex: Female Male SS# _____/_____/_____**PersonalE-mail**: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Your Employer Information **OK to call at work? ☐ YES ☐ NO**

Employer: _____ **Occupation**: _____

Address: _____ **City/State/Zip**: _____

WORK STATUS: ☐ Full time ☐ Part time ☐ Disabled ☐ Student

Spouse Information: Name: _____

Address: _____**City/State/Zip**: _____

Work Phone: _____ **Birth date**: _____ **SSN#**:_____

Spouse Employer Information

Employer: _____ **Occupation**: _____

Address: _____ **City/State/Zip**: _____

How did you hear about Dr. Tomalin? _____

Who is your primary care provider? _____

INSURANCE INFORMATION - ***Please provide your insurance card and driver's license when checking in:***

Who is responsible for this account? _____ _____ _____

Name of Insured: _____

Birth Date: _____ ***SS#*** _____/_____/_____

Relationship to patient: ☐***Self*** ☐ ***Spouse*** ☐ ***Child*** ☐ ***Other***_____

Insurance Carrier: _____ ***Group Number:***_____

If under 18 years: I hereby grant permission for my child to receive treatment by Dr. Greg. Tomalin or on-call colleagues:

ASSIGNMENT AND RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Greg S Tomalin, DC 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 by insurance. I authorize the use of my signature on all insurance submissions. Dr. Tomalin may use my health care information and may disclose such information to the above named insurance company, or other company(ies) and their agents for the purpose of obtaining payment for related services. This consent will be ongoing.

Signature (Parent or Guardian's signature if under 18 years of age):_____

Printed Name: _____

Date: _____ ***Relationship to patient:*** ☐ ***Self*** ☐ ***Spouse*** ☐ ***Child*** ☐ ***Other***