

# Ross Chiropractic Center

565 N. Magnolia Ave El Cajon, CA 92020 (619) 440-4035

## Patient Information

<b>Patient Name:</b> _____	
<b>DOB:</b> _____	<b>Doctor:</b> _____
<b>FILE #:</b> _____	
Office use only - please leave blank	

Patient Information		
Name _____		Contact Prefer: _____
Address _____		Telephone: _____
		Cell: _____
City _____	State _____	Zip _____
Email _____	Do You want to be added to our email list? _____	
Male [ ] Female [ ]	Date of Birth _____	Occupation _____
Social Security # _____	Drivers Lic # _____	
Primary Care Physicians Name _____	PCP Phone # _____	
Contact in Case of Emergency, Name _____	Telephone #: _____	
Insurance Company name _____	Insurance Co. Member service Phone # _____	Secondary Insurance _____
Member ID# _____	Primary Insured's Name _____	
Name of Parent of Minor or Legal Guardian (if Applicable): _____		
<b>Acceptance as Patient / Guardian</b>		
I understand and agree that the doctors of Ross Chiropractic Center have the right to bill my health insurance for me. They may use the information from me to contact my Insurance company to determine benefits (if any).		
I do understand that insurance verification is not a guarantee of benefits.		
I also authorize the Ross Chiropractic Center to bill my Insurance Company, on my behalf, and be paid directly from insurance company.		
Patient Name _____	Patient or Guardian Signature _____	Date _____