

# Welcome to the Russell Chiropractic Health Center

Date \_\_\_\_\_

PATIENT # \_\_\_\_\_

## PATIENT INFORMATION

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
☎ Phone

\_\_\_\_\_  
Cell Phone

Sex  M  F Birthdate \_\_\_\_\_

Single  Married  Divorced  Widowed

\_\_\_\_\_  
Patient Social Security #

\_\_\_\_\_  
Occupation

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Employer Phone

\_\_\_\_\_  
Spouse Name

## ACCIDENT INFORMATION

Is condition due to an accident?  Yes Date \_\_\_\_\_

Types of accident  Auto  Work  Home  Other

To whom have you made a report of your accident?  
 Auto Insurance  Employer  Worker's Comp  Other

\_\_\_\_\_  
Attorney's Name (if applicable)

## INSURANCE

\_\_\_\_\_  
Name of Insurance 1)

\_\_\_\_\_  
Name of Insurance 2)

SUBSCRIBER's BIRTHDATE: \_\_\_\_\_

\_\_\_\_\_  
Insured's name

\_\_\_\_\_  
Insured's Address

\_\_\_\_\_  
City State Zip

## Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage with above named insurance company and assign to Dr. Hubert Russell, Jr./ Russell Chiropractic Health Center P.C. all insurance benefits, if any otherwise payable to/by me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to be financially responsible for all charges incurred at this clinic, including my insurance deductible, co-payment, and any services rejected by my insurance company.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Relationship Date

## PATIENT CONDITION

Describe your complaint (symptoms) in detail

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