Thompson FAMILY CHIROPRACTIC
5734 West 13400 South Suite #200
Herriman, UT 84096
Telephone: 801.446.6220 Fax: 801.446.2166

PERSONAL INFORMATION

Please Print

First Name:_____ **M.I.**_____ Last Name _____ Preferred Name_____

Address:_____ City:_____ State:_____ Zip:_____

Birthdate: ____/____/____ Age _____ Gender: ☐ Male ☐ Female ☐ Unspecified

Primary Phone: _____ Cell Phone:_____ Work phone: _____

Home Email:_____WorkEmail:_____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Which Email would you like us to use to communicate with you (check one) ☐ Home ☐ Work

Contact Method: (check one) ☐ Primary Phone ☐ Cell Phone ☐ Home Email ☐ Work Email

\Status: (Check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated Children: ☐ Yes ☐ No

Spouse's Name: _____ Multi-Racial (check one) ☐ Yes ☐ No ☐ Unknown

Race: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ I choose not to specify

Ethnicity: ☐ Hipanic or Latino ☐ Not Hispanico or Latino ☐ I choose not to specify

Preferred Language: ☐ English ☐ Spanish ☐ French ☐ Japanese ☐ Chinese ☐ German ☐ Other_____

Occupation:_____ Employer:_____

Emergency Contact: (Name, Relationship, Phone#) _____

Family Physician Name:_____ City: _____

How were you referred to our office? ☐ Patient_____ ☐ Physician_____

☐ Google ☐ Facebook ☐ Office Website ☐ Location ☐ Attorney ☐ Other:_____

INSURANCE OR PRIVATE PAY INFORMATION

Please provide insurance card(s) to receptionist.

Type Of Insurance: ☐ Private Ins. ☐ Medicare ☐ Auto Ins. ☐ Worker's Comp ☐ Other_____

Primary Insurance Carrier: _____ Phone: _____

Policy#_____ Group#_____ Claim#_____

Is patient covered by insurance? ☐ Yes ☐ No

Secondary Insurance Carrie:_____ Policy# _____

ASSIGNMENT/AUTHORIZATION/RELEASE:

I certify that I, and/or my dependents, have insurance with the above named insurance company(s) and assign directly to Preferred Health of Marshall, PA all benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. I understand that "co pays" are payable at the time of each visit and that I am financially responsible for all charges whether or not paid by insurance. The above named provider's office my use my health care information and may disclose such information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining benefits payable for related services.

☐ Private pay/ Cash: By checking this box, I acknowledge that I do not have insurance and understand that I am financially responsible for all services at the time they are rendered. Name of person responsible for this amount:_____

X_____ DATE:_____

Signature of Patient, Parent or Legal Guardian (if minor)