New Patient Information
Kemp Chiropractic

Date _____

Patient's Name (Please Print)	Street Address	City and State	Zip

S.S. #	Sex		Marital Status					Birth Date	Age	Home Phone #	Cell Phone #
	M	F	S	M	W	D	Sep				

Email Address	Patient's or Parent's Employer	Business Phone # Ext. #

Whom May We Contact In Case of An Emergency?	Relation	Phone #

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE INFORMATION PRIOR TO BEING SEEN BY THE PHYSICIAN.

Person Responsible For Payment, If Not Above	Street Address, City, State	Zip	Home Phone #

Blue Cross Blue Shield (Give Name of Policyholder) ☐	Effective Date	Policy #	Group #

Other (Write In Name of Insurance Company) ☐	Effective Date	Policy #

Medicare # ☐	Railroad Retirement # ☐	☐ Visa ☐ MasterCard ☐ Check Card #

Is This Condition Due To An Accident? ☐ Yes ☐ No Date of Accident: _____	Type of Accident ☐ Auto ☐ Work ☐ Home ☐ Other	Attorney Name (if applicable)

Were X-Rays Taken of This Injury or Problem? ☐ Yes ☐ No	If Yes, Where Were X-rays Taken? (Hospital, etc.)	Date X-rays Were Taken

Whom May We Thank For Referring You To Us?

ALL PROFESSIONAL SERVICES REDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE BOOKKEEPER.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Name of Insurance Company(ies)

Kemp Chiropractic, P.A. 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.

Kemp Chiropractic, P.A. may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient