

DISCOVER CHIROPRACTIC

Dr. Jason Weigner

PATIENT:

Today's Date: _____

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: ___ / ___ / ___ SS#: _____

Please Circle: Male or Female Married or Single or Other Full-time or Part-time Student

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ Phone: _____

FAMILY:

Spouse's Name: _____

Children's Names: _____ Ages: _____

PRIMARY INSURANCE:

Please circle: MEDICAL AUTO WORKERS' COMP PERSONAL INJURY

Insurance Company: _____ Insured's Name: _____

ID #: _____ Group #: _____ Copay: _____

Insurance Address: _____

City: _____ State: _____ Zip: _____ Ins Phone #: _____

If Auto or Workers' Comp: Date of Injury: _____ Claim #: _____

Reason for coming in: _____

How did you hear about us? _____

Name of Previous Chiropractor: _____

Have you been treated for this condition in the last 12 months? _____

Have you had X-rays or treated with any other chiropractor in the last 12 months? _____

Is it possible that you are pregnant at this time? _____ Last Period Date: _____

Please Read, Sign and Date the following Statements:

X-rays are utilized in this office to help analyze vertebral subluxations only. These films are not used to investigate medical pathology. This office does not diagnose or treat medical conditions.

Patient or Guardian Signature _____ Date _____

I authorize payment of benefits directly to the provider of services rendered. I further authorize this office to release any information required to process insurance claims. I have read and understand the "Consent for Purposes of Treatment, Payment, and Healthcare Operations" form.

Patient or Guardian Signature _____ Date _____

I have fully read and completed this form. I understand that my insurance company is under no obligation to make payment on my behalf. I also fully understand that I am personally responsible for full payment for services and supplies if my insurance company denies my claim, makes partial payment or if my insurance company has not made payment within 45 days. I also understand that I am responsible for all deductibles and copayments required by my insurance plan. I further understand that it is my responsibility to inform this office of any change in my insurance, or my medical status, or if my insurance company has requested information from me, or if my insurance company has informed me of a delay or problem in processing claims.

I understand that this office participates with Pennsylvania Blue Shield. However, if my Blue Shield plan is from another state, payment may come to me. **I will sign over any checks to Dr. Jason Weigner that I receive from my insurance carrier for services rendered by him.**

Patient or Guardian Signature _____ Date _____

For Office Use Only

Effective Date: _____ Deductible Amount: _____ Has it been met? _____

Copay Amount: _____ % of Chiro Coverage: _____

Limitations (such as # of visits): _____

Dx Codes: _____

Sublux Level: _____

Date of X Ray: _____ Date of MRI: _____

First Date of Service: _____