Chiropractic Health Center of Parma, Inc.
9687 Brookpark Rd
Parma, Ohio 44129
Phone: 216-898-1445 Fax: 216-898-1447

Dear Patient: Please assist us by clearly and correctly completing the information in the outlined areas. Please give your driver's license and insurance cards to the receptionist so we may make copies for your file. Thank you!

PATIENT INFORMATION

First Name	Middle Initial	Last Name	Acct. # / Type

Patient's Sex	Age	D.O.B.	Social Security #:	Marital Status	Employment

Student	Street Address	City	State	Zip Code

Cell Phone #	Home Phone #	Job Description

Email:

BILL TO INFORMATION

First Name (if different than patient)	Middle Initial	Last Name (if different than patient)

Street Address (if different that patient)	City	State	Zip Code

PRIMARY COVERAGE

Primary Insurance Company Name and Address

Employer	Primary Insurance Co. Certificate or Contract #	Group # of Employee

Name of Policy Holder	S.S. # of Policy Holder	D.O.B. / /	Patient Relationship to Policy Holder Self Spouse Son Dau Parent Other

AUTHORIZATION - The above subscriber hereby authorizes his/her insurance company to issue indemnity checks to the above listed medical provider for services provided.

I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services and authorize such physician OR organization to submit a claim to my insurance carrier for payment. I authorize any holder of medical or other information about me to be released to insurance carriers OR the Health Care Financing Administration and its agents OR the Social Security Administration OR its intermediaries OR any agency, group or person(s) necessary to secure payment any information needed from this. For and in consideration of services rendered and to be rendered by the above listed medical provider, I hereby guarantee payment of all charges incurred for this account. This patient or his / her representative recognizing the need for health care, consent to x-rays, examinations or other services rendered under the general and specific instructions of the physicians. I certify that the information given by me in applying under Title XVIII of the Social Security Act is correct.

Signature:	Date: