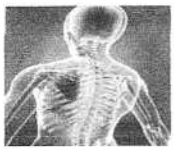

Advanced Chiropractic and Nutrition
54 The Legends Parkway, Ste 154
Eureka, MO 63025
636-938-1010

Patient/Insurance Information

Last Name:		Marital Status: (circle one)	
First Name:	MI:	Single Married Divorced Widowed	
Email:		Birthdate:	Sex:
Address:	City:	State, ZIP:	
SS#:	Home #:	Cell #:	
Employer:		Work #:	
Address:	City:	State, ZIP:	
Occupation:	Emergency Contact Name:		
Emergency Contact #:		Relationship:	

Primary Insurance Information

Policyholder's Name:		Home #:	
Policyholder's Employer:		Work#:	
Policyholder's SS#:	Relationship to Patient:		
Policyholder's Birthdate:		Policy #:	
Name of Insurance Company:			Group #:

If you have secondary insurance, please fill out the section below. If not, please skip this section and proceed to the signature section.

Secondary Insurance Information

Policyholder's Name:		Home #:	
Policyholder's Employer:		Work#:	
Policyholder's SS#:	Relationship to Patient:		
Policyholder's Birthdate:		Policy #:	
Name of Insurance Company:			Group #:

Signature

I agree to pay for services rendered. I understand that it is my resposibility to know my health plan coverage and co-pay/co-insurance. I understand payment is expected at the time of service. I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself and that I am personally responsible for payment of any and all provided services covered or non-covered. I also understand that if I terminate care and treatment, any fees for services rendered to me will be immediately due and payable. I hereby authorize any direct payment of any services expense benefits allowable to the doctor as payment toward the total charges for services. I agree that a photocopy of this agreement shall serve as the original.

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

Date

Print Name of Patient/Parent (if minor) or Legal Guardian