

WELCOME SHEET

(Please Print)

Today's date:		PCP:					
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:			Social Security #:		Home phone #:		CellPhone#:
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone #: ()		
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:					E-Mail:		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ()		
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance		<input type="checkbox"/> BlueCross/BlueShield	<input type="checkbox"/> Cigna	<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Aetna	<input type="checkbox"/> Medicare
<input type="checkbox"/> TennCare		<input type="checkbox"/> Other:				
Subscriber's name:		Subscriber's Social Sec #:	Birth date: / /	Group #:	Policy #:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	
Name of secondary insurance (if applicable):		Subscriber's name:		Group #:	Policy #:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Leath Chiropractic or my insurance company to release any information required to process my claims. I agree to pay all cost of collection if my account becomes delinquent, including attorney fees and all other court cost if a lawsuit is filed against me.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	