BACKCOUNTRY CHIROPRACTIC
1354 NW GALVESTON AVE ◆ BEND OR 97701
(541) 385-5900 ◆ Fax (541) 385-6900

**PATIENT INFORMATION**

Patient's Name_______________________________________________Date______________________

Address__________________________________City__________________State_______Zip___________

Telephone____________________Email ___________________Social Security #_______-_____-________

Date of Birth______/______/______ Age__________ Gender: M / F Marital Status: M / S / D

Occupation______________________Employer ___________________________Years Employed________

Address _______________________City____________State ______Zip _________ Phone________________

Spouse's Name_________________ Employer_________________ Family Physician__________________

Emergency Contact Name/Relationship_________________________________Phone_________________

Whom may we thank for referring you to us?____________________________________________________

**INSURANCE INFORMATION (please present insurance cards for all coverage)**

Insured's Name________________________________ Insured's Date of Birth ______/______/______

Insured's Employer___________________________ Insured's Social Security #_______-_____-________

Patient's Relationship to Insured: *Self* *Spouse* *Dependent* *Other*__________________________

Do you have Chiropractic Benefits on your plan? *Yes* *No* *Uncertain*

Primary Insurance Company Name ____________________________________________________________

Primary Insurance ID #________________________Primary Insurance Group #_______________________

Primary Insurance Claims Address_________________________________Phone_______________________

**ACCIDENT/INJURY/ATTORNEY INFORMATION**

Please Indicate Type of Accident: Workers Compensation Motor Vehicle Personal Injury Other

Date of Accident/Injury____________Time of Accident/Injury___________Claim #_____________________

Patient's Car/Work Comp Insurance Co.________________________Adjuster/Supervisor________________

Attorney Name_____________________Address__________________________Phone_________________

I hereby affirm the above to be accurate, and consent to chiropractic care in this office.

Patient's Signature ________________________________________________ Date _______________
(Guardian must sign for all patients 17 years old or younger)