



Drummond Chiropractic, L.L.C.
4712 East State Road 46, Blgtn IN 47401

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 W. D. Drummond, D.C.

PATIENT INFORMATION

Patient's Name: _____
 Home Address: _____
 City: _____ State: _____ Zip: _____
 Home #: (____) - ____ - _____ Social Security Number: _____
 Date of Birth: _____ Nick Name: _____
 Circle one: Male / Female Referred by: _____
 Circle one: Employed / Part-time student / Full-time student / Other: _____
 Employer's Name: _____ Type of Work: _____
 Work #: (____) - ____ - _____ E-mail: _____
 Circle one: Married / Single / Widowed / Divorced / Other: _____
 Emergency Contact: _____ Home #: (____) - ____ - _____

PRIMARY INSURANCE INFORMATION

Note: if patient is the primary insured – this section does not need to be filled out (as same as information above)

Patient Relationship to Insured: (circle one): SPOUSE / CHILD / OTHER: _____
 Name of Insured: _____ Circle one: Male / Female
 Home Address: _____
 Home Phone #: (____) - ____ - _____ Work Phone #: (____) - ____ - _____
 SSN: _____ Insured Date of Birth: _____
 Circle one: Married / Single / Widowed / Divorced / Other: _____
 Circle one: Employed / Part-time student / Full-time student / Other: _____
 Insured's Employer: _____ Occupation: _____

SECONDARY INSURANCE? YES / NO

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my health care and treatment, any fees for professional services rendered to me will be immediately due and payable.

By my/our signature(s) below, I/we accept full responsibility for payment of services provided by this office. Should my/our account become delinquent, I/we agree to also pay all costs of collection of this account including, but not limited to: collection agency fees, legal costs and attorney fees.

Patient's signature: _____ Date: _____

Spouse's / Guardian's Signature: _____ Date: _____