

Patient Information

Well adjusted for life!

Date _____

Name _____ I prefer to be called _____

Address _____

City _____ State _____ - _____ Zip _____

E-mail address _____

Home Phone _____ Cell Phone _____ Work Phone _____

SS # _____ Birth Date _____ Age _____

Employer/Occupation _____

Who can we thank for referring you to us? _____

Emergency Contact

Name _____ Relationship _____

Home Phone _____ Cell or Work Phone _____

Insurance Information

Insurance Company _____ Phone _____

Do you have secondary insurance? _____ Name _____

I hereby authorize and request my insurance company to pay GLC/Dr. Steven Polenz the amount due on my claim for services rendered to me and/or my dependent. I hereby authorize the release of all information necessary to secure the payment of the benefits. I authorize the use of this signature on all insurance submissions. I authorize GLC/Dr. Steven Polenz and whomever he may designate as his assistants to administer care, as he deems necessary.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF CHIROPRACTIC CARE REGARDLESS OF THE INSURANCE COVERAGE.

Patient Signature _____

Parent/Guardian Signature _____