Qin Acupuncture & Chiropractic Clinic • 855 E. Palatine Rd. Ste. 170 • Palatine, IL 60074

PATIENT INFORMATION

Date:_____ Referred by:_____

Last Name:_____ First Name:_____ Middle Initial:_____

Date of Birth:_____/_____/_____ Age:_____ Sex: □Male □Female □ Soc. Sec._____-_____-_____

Home Address (No PO Boxes):_____Apt/Unit:_____

City:_____State:_____ZIP:_____

Home Phone:_____Cell Phone:_____

Work Phone:_____ Email:_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed Occupation: _____

Are you pregnant? □ Yes □ No Are you a student? □ Full-time □ Part-time □ Non-student

EMERGENCY CONTACT

Contact Person:_____Relation to Patient: _____

Home Address (No PO Boxes):_____Apt/Unit:_____

City:_____State:_____ZIP:_____

Home Phone:_____Cell Phone:_____

INSURANCE INFORMATION

Who is responsible for your bill? □ Self □ Spouse □ Parent/Guardian □ Insurance □ Employer □ Other:_____

Type of insurance: □ Health □ Worker's Comp. □ Automobile □ Other:_____

Company Name:_____ Type: □ PPO □ HMO □ Other:_____

Policyholder's Name:_____ Relation to Patient: _____

Please provide a copy of your insurance card and any information relevant to the processing of your claim.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNEMNT OF BENEFITS

I hereby authorize the release any information in the course of my treatment or examination to my insurance carrier.

I hereby authorize payment of insurance benefits due me to Physician for services rendered. I understand I am responsible for payment of co-pays, deductibles and all other cost sharing.

I understand that I am responsible for charges not covered by my insurance, which are due and payable upon service, unless other arrangements have been made in advance. I am aware that the clinic will charge me a 2% per month late fee for all bills paid later than 30 days of the statement date.

I, the undersigned, hereby give permission for treatment.

Signed:_____ Date:_____