

**COBB CHIROPRACTIC CLINIC  
ADMITTANCE INFORMATION**

ADMITTANCE DATE: \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ SEX: MALE / FEMALE  
(LAST) (FIRST) (MIDDLE)

EMAIL: \_\_\_\_\_ CIRCLE ONE: SINGLE / MARRIED / DIV / WID

HOME ADDRESS: \_\_\_\_\_  
(STREET / APT. #) (CITY) (STATE) (ZIP CODE)

MAILING ADDRESS: (IF DIFFERENT) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ CHILDREN: 1 / 2 / 3 / 4 / 5 / 6 / 7 N/A  
(MONTH) (DAY) (YEAR)

PROFESSION / OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

SPOUSE OR PARENT:: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
(MONTH) (DAY) (YEAR)

HAVE YOU HAD CHIROPRACTIC CARE BEFORE: YES / NO WHERE: \_\_\_\_\_

EMERGENCY CONTACT: NAME & PHONE \_\_\_\_\_

HOW HAVE YOU BEEN REFERRED: ex. (TV) \_\_\_\_\_

**INSURANCE INFORMATION**

DO YOU HAVE MAJOR MEDICAL HEALTH INSURANCE: YES / NO

GROUP OR PERSONAL: \_\_\_\_\_

COMPANY: \_\_\_\_\_ POLICY # \_\_\_\_\_

WORKERS COMP: YES / NO MEDICARE: YES / NO MEDICAID: YES / NO

MEDICAL PAY: \_\_\_\_\_ LIABILITY: \_\_\_\_\_

DRIVER: \_\_\_\_\_ DRIVER: \_\_\_\_\_

ISSUED BY: \_\_\_\_\_ ISSUED BY: \_\_\_\_\_

OWNER: \_\_\_\_\_ OWNER: \_\_\_\_\_

ATTORNEY: (IF YOU HAVE ONE) \_\_\_\_\_

**INFORMATION FOR THE NEW PATIENT:**

A thorough understanding of our fees and procedures is necessary in order to maintain a good doctor / patient relationship – a factor which is very important in gaining maximum recovery. Therefore, we want you to feel free to discuss our recommendations or fees with us at any time.

Nearly all insurance policies provide chiropractic coverage, but benefits vary on each company and policy. Therefore, although we will fill out the insurance forms, **THE PATIENT IS RESPONSIBLE FOR PAYMENT OF BILL.** We do accept certain insurance assignments, but all insurance arrangements must be approved in advance.

We ask that you take care of your insurance co-pay as you go rather than have a large balance at the end of treatment. Don't hesitate to ask us about any questions you may have.

Please check the type of care desired so we may be guided by your wishes when possible.

- RELIEF CARE
- CORRECTIVE CARE
- COMPREHENSIVE CARE
- LET THE DOCTOR SELECT TYPE OF CARE HE FEELS IS BEST

In the event that an X-ray examination is required to help establish proper diagnosis, I realize that every precaution will be taken to insure my safety. (Females) To the best of my knowledge, I am not pregnant at this time.

DATE: \_\_\_\_\_

PATIENT'S SIGNATURE: \_\_\_\_\_

Note: In the event that you request your X-Rays records, North Carolina law requires that we give you a written report of the findings. We will provide a complimentary digital copy of your X-rays on request. Should you need a second copy there will be a charge that will be your responsibility – it is not covered by insurance.