KAISER CHIROPRACTIC, S.C.

PATIENT UPDATE FORM

PERSONAL INFORMATION			
NAME:			DATE:
PREFERRED NAME:		DATE OF BIRTH	SSN:
BOTH PHYSICAL AND MAILING ADDRESSES ARE REQUIRED IF THEY ARE DIFFERENT			
PHYSICAL ADDRESS:		CITY:	STATE/ZIP CODE:
MAILING ADDRESS:		CITY	STATE/ZIP CODE:
PLEASE CHECK HOW YOU WOULD PREFER US TO CONTACT YOU REGARDING YOUR CARE			
☐ HOME PHONE:	☐ CELL PHONE:	☐ EMAIL ADDRESS:	
☐ YES ☐ NO I WOULD LIKE TO RECEIVE APPOINTMENT REMINDERS EITHER BY PHONE OR BY E-MAIL AFTER JANUARY 1, 2011			
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED			NO. OF CHILDREN:
OCCUPATION (EVEN IF RETIRED):	EMPLOYER:	WORK#:	HOW LONG THERE?
EMPLOYMENT STATUS: ☐ FULL-TIME ☐ PART-TIME ☐ SELF-EMPLOYED ☐ UNEMPLOED ☐ RETIRED IN ________________			
SPOUSE'S NAME:	SPOUSE'S PHONE:	SPOUSE'S EMPLOYER:	SPOUSE'S WORK PHONE:
STUDENT STATUS: ☐ NON-STUDENT ☐ FULL-TIME ☐ PART-TIME			
EMERGENCY CONTACT INFO: (NAME, PHONE # & RELATIONSHIP)			
DO YOU HAVE INSURANCE SUPPORT? ☐ YES I DO AND I WILL PRESENT MY INSURANCE CARD TO BE COPIED AND SKIP THE GRAY AREA BELOW ☐ YES I DO, BUT I WILL FILL OUT THE GRAY AREA BELOW MYSELF ☐ NO I DO NOT HAVE INSURANCE SUPPORT			
PRIMARY INSURANCE CO:	PHONE:	ID OR POLICY#:	GROUP #:
POLICY HOLDER'S NAME: IF SELF; SKIP FOLLOWING QUESTIONS	THEIR EMPLOYER:	THEIR DATE OF BIRTH:	RELATIONSHIP TO YOU:
IF YOU HAVE SECONDARY INSURANCE COVERAGE, PLEASE PROVIDE THAT INFO ON THE BACK OF THIS FORM.			

- I hereby give permission to Dr. Kaiser & Kaiser Chiropractic, S.C. to administer treatment and perform such general procedures, as deemed necessary in the diagnosis and/or treatment of my condition.
- I hereby authorize and direct my insurance benefits to be paid directly to the doctor.
- I acknowledge that I am always responsible for all care left unpaid by my insurance regardless of the reason. This includes charges that are outside of the network benefits/ policy limits, care that is termed not medically necessary, maintenance/routine care, ineligible or non-covered services.
- I understand that delinquent accounts accumulate at 12% interest annually.

I do agree to these terms.

Patient Signature: ____ Date: ______________________

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