Paul A. Chandler, DC
NEW PATIENT INFORMATION FORM

(Please Print)

Today's date:	Name you prefer to be called:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Widowed

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City:	State / Zip Code

Home phone: ( ) -	Cell phone: ( ) -	

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box):	❑ Friend ❑ Family	❑ Insurance Plan	❑ Hospital or Dr.

❑ Close to home/work		❑ Yellow Pages	❑ Website	❑ Other

Do you have children living at home? ❑ Yes ❑ No List the name(s) and birth date(s) below

1.

2.

3.

4.

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please indicate primary insurance	❑ Aetna	❑ BCBS	❑ Cigna	❑ Medicare	❑ United Healthcare ❑ Other

Subscriber's name:	Subscriber's Birth Date / /	Male or Female	Insurance ID #:	Group #:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Insurance ID#:	Group #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Paul A. Chandler, DC or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

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