John K. Maltby, D.C.
Chiropractor

PATIENT INFORMATION

____BIRTHDATE___________AGE_____SEX___M____F
FIRST MI LAST

IF PATIENT IS A MINOR, NAME OF PARENT, GUARDIAN ____

MAILING ADDRESS: ____
STREET CITY ZIP

HOME ADDRESS: ____
(IF DIFFERENT FROM ABOVE) STREET CITY ZIP

HOME PHONE: ______________________________ALTERNATE PHONE (Cell):______________________________

PATIENTS EMPLOYER: ___________________________________OCCUPATION_____________________________

BUSINESS ADDRESS: ____
STREET CITY ZIP BUSINESS PHONE

MARITAL STATUS: ___ Single ___ Married ___ Widowed DATE SYMPTOMS BEGAN: _______________

EMAIL:___________________________________ HOW DID YOU HEAR ABOUT US? _________________________

INSURANCE INFORMATION: **Please provide SSN if Worker's Comp Case: ______-____-_______**

____MEDICARE____GROUP HEALTH INS___SECONDARY____CASH___**WORK COMP** ___**AUTO** **Date of Injury:**_________

RELATIONSHIP TO INSURED?___SELF___SPOUSE___CHILD___OTHER INSURED'S NAME:___________________

INSURED'S EMPLOYER: Same as above___ or ______________________________INSURED'S DOB: ___/___/_________

PRIMARY INS CO: ___________________________________ ID NUMBER__________________________________

ADDRESS____PHONE______________________________

SECONDARY INS CO: _____________________________________I D NUMBER_____________________________

INSURED'D NAME:______________ DOB:___/___/_____ EMPLOYER:_______________________________________

ATTORNEY____
NAME ADDRESS PHONE/FAX

I HERBY AUTHORIZE MY INSURANCE OR ANY THIRD-PARTIES BENEFITS BE PAID DIRECTLY TO JOHN K. MALTBY, DC AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICAN TO RELEASE MY MEDICAL INFORMATION REQUIRED TO PROCESS ALL CLAIMS.

IF NO INSURANCE BENEFITS ARE AVAILABLE, I AM SOLEY RESPONSIBLE FOR ALL SERVICES I RECEIVE.

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE PRIVACY POLICY OF JOHN K. MALTBY, D.C.

SIGNATURE: ____
DATE

320 E. HOBSONWAY BLYTHE, CA 92225
PHONE-(760)922-7353 FAX (760) 922-9121