John K. Maltby, D.C.
Chiropractor

PATIENT INFORMATION

_____BIRTHDATE_____AGE_____ SEX____M _____F
FIRST MI LAST (Nombre) (Fecha de Nacimento) (Edad) (Sexo)

IF PATIENT IS A MINOR, NAME OF PARENT, GUARDIAN _____
(Padre o Madre o Guardian)

MAILING ADDRESS: _____
(Direccion) STREET CITY ZIP

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

HOME PHONE: _____ALTERNATE PHONE (Cell):_____
(Numero de Telefono)

PATIENT'S EMPLOYER: _____OCCUPATION_____

BUSINESS ADDRESS: _____
STREET CITY ZIP BUSINESS PHONE

MARITAL STATUS: ____ Single ____ Married ____ Widowed Date Symptoms Began: _____

EMAIL: _____ How did you hear about us? _____

HEALTH INSURANCE INFORMATION: (We need a copy of all insurance cards)

Work Comp Case please provide SSN _____-____-_____ (Must have written pre-authorization) Skip to bottom of page & sign.

My Insurance is: _____ No Insurance (Skip to Bottom of Page and Sign)

_____MEDICARE & _____MEDICARE SUPPLEMENT OR _____MEDICARE ADVANTAGE PLAN

_____GROUP/PRIVATE HEALTH(Plan Name_____) SECONDARY HEALTH(Plan Name_____)

The insurance is through: ____MYSELF ____ MY SPOUSE/PARTNER ____MY PARENT ____ OTHER

Primary Insured Name, Birthdate, Employer:_____

Secondary Insured Name, Birthdate, Employer:_____

AUTO ACCIDENT: Your Auto Insurance:_____ Claim #:_____
PERSONAL INJURY: Name/Place of Injury:_____ Claim#:_____

Adjuster Name: _____ Phone#:_____Fax#:_____

Attorney: _____
Name Phone/Fax

_____
Address

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

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

SIGNATURE: _____

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