Kim K. Fuller, D.C.

PATIENT INFORMATION FORM

PATIENT INFORMATION

Patient's last name:	First:	MI:	Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Date of Birth:	Age:	Gender: ☐ Female ☐ Male	Number of children:

Address:	City:	State:	Zip:

Home Phone:	Cell Phone:	Work Phone:

EMPLOYMENT INFORMATION

Occupation:	Employer:	Employer phone:

INSURANCE INFORMATION *(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)*

Person responsible for bill:	Address (if different):	Phone:

Primary insurance:	ID #:	Group #:

Subscriber's name:	Subscriber's date of birth	Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

Secondary insurance:	ID #:	Group #:

Subscriber's name:	Subscriber's date of birth:	Relationship to subscriber: ☐ Self ☐ Spouse ☐ Child

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone:	Cell Phone:

HIPAA ACKNOWLEDGEMENTS: ALL PATIENTS MUST INITIAL ALL THAT APPLY:

_____ I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Policies of Kim K. Fuller, D.C.

_____ It is ok to leave a message regarding my health information at my: ☐ Home ☐ Cell ☐ No Messages

_____ By default, no other persons may have access to my medical record except the following person/people:

Name & Relationship:

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 Kim K. Fuller, D.C. or insurance company to release any information required to process my claims.

Patient/Guardian Signature: Date: