

Welcome to our Chiropractic Clinic

Advanced Back Solutions Inc. Dr. Kevin Venerus D.C.

Name: _____ Date: _____

Address: _____ Marital Status: S M D W

City, State Zip: _____

Phone (H) _____ Phone (W) _____ Date of Birth: _____

Email Address: _____

Occupation: _____ Social Security Number: _____

Spouse Name: _____ Spouse Employer: _____

Referred By: _____ ER Contact /Phone: _____

Insurance and Billing Information

Primary: _____ Secondary: _____

Subscribers Name: _____ Relationship: _____

Social Security Number: _____ Date of Birth: _____

Assignment of Insurance Benefits and Authorization to Release Information

Payment is required at the time of service unless prior arrangements have been made. I hereby authorize direct payment of medical benefits to Dr. Venerus for services rendered by him in person or under his supervision. I understand that I am responsible for any balance not covered by my insurance carrier, workers comp, or auto carrier. I hereby authorize Dr. Venerus to release any medical information that may be necessary for either medical care or in processing applications for financial benefit. In situations where the same/similar services are provided over a period of time, this single notice will suffice. By signing this, I understand that I am agreeing that either my physician or his staff has briefly gone over this with me, and has answered all my questions regarding this notification.

Patient (Legal Guardian Signature): _____ Date: _____