HORNBERGER WELLNESS & CHIROPRACTIC

4001 Swift Rd, 1st floor
SARASOTA, FL 34231

PATIENT INFORMATION: **Today's Date**: ___________________

Patient's First Name ___________________, **Middle Initial**: _______, **Last Name**: ____________________________________

Address _____________________________________ **City** __________________________**State** ________**Zip** _____________

Cell Phone: _________________**Hm Phone:** ___________________ **Wk Phone:** __________________ **Birth date** ___/___/_____

☐ **Male,** ☐ Female, **SS#**______________________________ **Marital Status**: ☐ M, ☐ S, ☐ W, ☐ D Student: ☐

Who referred you? Name: ____________________________________, Spouse: _____________, Spouse Phone: _______________

Language: ________________________, **Race**: (optional): ____________________, **Ethnicity** (optional): ___________________

Email: Home: ______________________________________, Work: ____

Contact Preference: ☐ Cell Phone, Cell Phone Carrier ____________________________; ☐ Home Phone ☐ Work Phone,
Can we Text you? ☐YES ☐ NO, Can we email you? ☐YES ☐NO
Can we call or contact you? Home: ☐YES ☐NO, **Work:** ☐ YES ☐ NO, **Cell:** ☐YES ☐ NO

Insurance Information

Insurance Carrier: ____________________________ Policy Holder (name on card): _______________________________________

Policy Number: ____Work Phone__________________________

Please provide our office with your insurance card and Photo ID

TO BE FILLED OUT BY OFFICE BILLING DEPARTMENT:

Type: ☐ ChiroHeath USA, ☐ Private, ☐ Cash, ☐ Auto, ☐ Worker Compensation, ☐ Slip & Fall

Primary Insurance Company____

Policy No. ________________________________, ChiroHealsthUSA,______________________

Name of Person Responsible for Payment____

Insurance Address____

Name of Person Spoken to: ____

Chiropractic Coverage: Yes_____No____Deductible: _______________DeductibleMet: _______________

Coverage: ____

Adj 1-2 regions (98940) : ____________, Adj 3-4 regions: ____________, MM1-2 regions (98940): __________
MM# 3-4 regions (98941): ___________, X-rays: ____________________, Massage: (97124): _______________
EMS (97014): ______________________, IT (97012: ________________, Exercise (97140) ________________
US (97035): ________________________, MH (97010): ______________, ICE (97010): ___________________
Limitations: ____
Additional Information: ____

Assigned Provider: ☐ Michael Hornberger, DC ☐ Joseph Hornberger, DC ☐ Craig Bow, D