

Elite Care Chiropractic  
317 N. El Camino Real, Suite 109 Encinitas, California 92024  
Phone: (760) 634-3701 Fax: (760) 944-7151

## PATIENT INFORMATION

First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name: \_\_\_\_\_

Sex: M \_\_\_\_\_ F \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: S \_\_\_\_\_ M \_\_\_\_\_ W \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

E-mail: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Employer: \_\_\_\_\_

City: \_\_\_\_\_ Work or Alternate Phone: ( ) \_\_\_\_\_

Job Title or work responsibilities: \_\_\_\_\_

Referred by: \_\_\_\_\_

Cause of complaint: Auto Accident \_\_\_\_\_ Work Injury \_\_\_\_\_ Athletic Injury \_\_\_\_\_ Other Injury: \_\_\_\_\_

Are you or do you think you may be pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

Method of Payment:

Cash: \_\_\_\_\_ Medical Insurance: \_\_\_\_\_ Worker's Comp: \_\_\_\_\_  
(We take cash, checks or Visa/Mastercard/Discover cards)

Auto Insurance: \_\_\_\_\_ Med Pay: \_\_\_\_\_ Lien: \_\_\_\_\_

Person Responsible for Account: \_\_\_\_\_ Relation to you: \_\_\_\_\_

IN CASE OF EMERGENCY, CONTACT:

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection cost and reasonable attorney fees as may be required to effect collection.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_