Good Vibrations Family Chiropractic

Insurance Verification Form

Please complete the following information only if you would like us to check into any insurance coverage you may have for chiropractic care through your insurance company. We will also need to take a copy of your insurance card so make sure you have it with you.

Today's Date: ________/__________/__________
Name: ____
Birthdate: ___________/___________/____________
Social Security #______________________________
Mailing Address: ____
____
Home Phone: __________________________
Work Phone: __________________________
E-mail Address: ____
Employer: ____
How long have you been at this job: ____________________
Employer's address: ____
____
Occupation: ____

IF you are not the primary person covered for your insurance, please include the following information on the primary person insured (eg Spouse, partner, parent)

Name: ____
Birthdate: ___________/____________/_____________
Social Security #: ________________________________
Work Phone: _______________________
E-mail Address: ____
Employer: ____
How long have they been at this job: ____________________________________
Employer's address: ____
____
Occupation: ____
Relation of insured to you: ____

Please describe your pain and its location: ______________________________
____
When did it begin? ____
Is it getting worse? ____
Is it interfering with your work/sleep/daily routine? ____________________________
Have you had this in the past? ______________________________________
Have you been treated by a Medical Physician for this condition? _____ yes _____ no
If so where? ____
Have you ever been treated by a chiropractor before? _____ yes _____ no
If so, whom? ________________________________ Phone: _______________