

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: _____