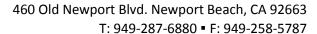


CONFIDENTIAL PATIENT INFORMATION

How did y	ou hear about us?			
☐ Patient: ☐ Health Care	Provider:	Insurance Company		
☐ Newspaper ☐ Internet/Website ☐ Health	n Fair 🗆 Other:			
Full Name (First, Middle, Last):				
Home Phone:	Cell Phone:			
Work Phone:	Email:			
Preferred contact method: ☐ Home phone	□ Cell phone	☐ Work phone ☐ Email		
Address:				
City:	State:	Zip:		
DOB:	Age:	Sex: M / F		
Social Security Number:	al Security Number: Driver's License:			
Marital Status: S / M / D / W Spouse's Nam	e:	# of Children:		
Occupation: Busi	iness/Employer Name:			
Address:				
City:	State:	Zip:		
Primary Care Physician:	Phone:			
Preferred Pharmacy:				
☐ I hereby give permission to release information	related to my care to r	ny family physician.		
Emergency Contact: Phone:				
Emergency Contact Relationship				
IF YOU WERE INVOLVED IN AN ACCIDENT PLEASE COMPLETE THE FOLLOWING:				
Did the injury occur at WORK? Yes / No Date of	Injury:	Time:		
Has the injury been reported to your supervisor?	Yes / No Name of su	pervisor:		
Is the injury a result of an AUTOMOBILE ACCIDENT? Yes / No OTHER?				
I hereby certify that the preceding questions have been an belief. I understand that ARC Healthcare is a professionally	•			
Patient/Guardian Signature:		Date:		





IF YOU WILL BE USING INSURANCE BENEFITS TO COVER SERVICES, PLEASE COMPLETE AND SIGN BELOW:

Insurance Company:		Group / Policy #:	
Medicare: Yes / No Policy I	Number #:	Effective Date:	
Name of Primary Insured (F	irst, Middle, Last):		
Relationship to Insured:		DOB of Primary Insured:	
the following address. If n		to pay by check made out to and mailed directly to lirect payment to doctor, then I hereby also nd mail it as follows:	
	ARC Heal 460 Old Newport Blvd. Ne		
payment toward the total charge BENEFITS UNDER THIS POLICY. T agreed to pay in current manner payment. I further understand t may be referred to by ARC Healt	es for professional services rende his payment will not exceed my ir any balance and/or co-pay of sai hat I will be responsible for paym hcare and any emergency transpo	therwise payable to me under my current insurance policy as red. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND ndebtedness to the above mentioned assignee, and I have d professional service charges over and above this insurance lent to any other facilities and/or health care providers that I porting that may be required thereto. I also authorize the company, adjuster or attorney involved in the case.	
Patient or Insured Signatu	re:	Date:	
IF YOU DO NOT HAV	E INSURANCE THAT COVER	S SERVICES, PLEASE READ AND SIGN BELOW:	
are payable when treatme any other facilities and/or emergency transporting the I further acknowledge that	nt is rendered. I further un health care providers that I hat may be required thereto at the fees I am paying are	discounted from the usual and customary fees	
	–	e being applied to the usual fees. In the event use a third party payer, the standard fees may	
Patient/Guardian Signatu	re:	Date:	
FOR OFFICE USE ONLY:			
Deductible	Deductible met_	Copay/Coinsurance	
OON Benefits:	OOP Max	Chiro/PT Benefits	
Verified by		Date	

Revised: 7/16