Graceful Waves Chiropractic

278 Rowe Street, Ste 210, Wheeler, OR 97147-0035
(503) 368-9355

PATIENT BILLING RECORD

Patient Information

Last Name: _____

First Name: _____ MI ____

Address: _____

City State Zip: _____

Home #: _____

Work #: _____

Cell #: _____

SS#: _____

Date of Birth: _____ **M or F**

Student: Full-time or Part-time

Spouse/Parent Info

Last Name: _____

First Name: _____

Date of Birth: _____

~~Policy Holder Information~~

~~**Name:**~~ _____

~~**Address:**~~ _____

~~**City State Zip:**~~ _____

~~**SS#:**~~ _____

~~**Date of Birth:**~~ _____

~~**Relationship to Patient:**~~ _____

~~**Employer:**~~ _____

~~Patient Employment~~

~~**Name:**~~ _____

~~**Address:**~~ _____

~~**City State Zip:**~~ _____

~~Full-time~~ ~~Part-time~~ ~~Retired~~

~~**Job Title:**~~ _____

Motor Vehicle Accident Insurance Info.

Is this the result of an auto or work accident? Y or N

Date of Accident: _____

Insurance Co. Name:

_____

Adjuster Name: _____

Phone #: _____

Claim #: _____

~~Heath Insurance Info.~~

~~**Primary Insurance Company:**~~

_____

~~**Address:**~~ _____

~~**City State Zip:**~~ _____

~~**Phone:**~~ _____

~~**Card ID #:**~~ _____

~~**Group #:**~~ _____

~~**Secondary Insurance Company:**~~

_____

~~**Address:**~~ _____

~~**City State Zip:**~~ _____

~~**Card ID #:**~~ _____

~~**Group #:**~~ _____

I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I authorize the release of medical information to determine the benefits payable by insurance for related services. Furthermore, I understand that the Doctor's office will prepare any necessary forms and reports to assist me in make collection from the Insurance Company and that any amount authorized to be paid directly to the Doctor will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged to my account directly and I am responsible for payment.

_____

Signature Patient/Responsible Party