Harmonic Life Chiropractic Center
757 W. 9th St
San Pedro, Ca 90731
(310) 856-7999

Patient Information

Name: ____
Last First MI

Gender ☐ M ☐ F Social Security: ____________________

Birth Date __________ Email Address: ____________________

Mailing Address: ______________________________________

City: ____________________ State: __________ Zip: __________

Phone # (H) __________ (C) __________ (Other) __________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Latin American ☐ Other ______

Occupation: ____________________ Employer: ____________________

Employer Address: ____________________ Phone: ____________________

Emergency Contact: Name: ____________________ Relation: ____________________

Phone: (H) __________ (W) __________ (Other) __________

Accident Information

Is this visit due to an accident? ☐ Yes ☐ No If yes, what type? ☐ Auto ☐ Work ☐ Other__________

Has it been reported? ☐ Yes ☐ No If Yes, to whom? ____________________

Insurance Information

Policy Holder Name: ____________________ D.O.B. __________

Relation to Patient (if other than self): ____________________ Phone: __________

Do you have health insurance? ☐ Yes ☐ No Name of Carrier: __________

Do you have secondary insurance? ☐ Yes ☐ No Name of Carrier: __________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with ____________________, and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Signature (X) ______________________________ Date __________