Family Wellness Centers

Date: _____

Patient Information (Please Print):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

How did you hear about us? _____

Email Address: _____ May we add to Email List? Yes { } No { }

Date of Birth: ____ /____ /_____ Age: _____ Sex: M { } F { }

Home Phone: _____ Cell Phone: _____ Preferred # _____

Social Security # _____-_____-_____ Marital Status: { } Single { } Married { } Widowed

Emergency Contact: _____ Phone: _____

Patient's Employer: _____ Work Phone: _____

Insurance Information: (Please provide a copy of insurance Card)

Primary Insurance Name: _____ ID# _____

Secondary Insurance Name: _____ ID# _____

Insurance Policy Holder *(person who carries insurance):*

Name: _____ Date of Birth: _____ / _____ / _____

Relationship to Policyholder: _____ Social Security # _____-_____-_____

Address ***(if different than above)***: _____

Employer of Insurance Holder: _____ Phone: _____

I authorize AAC Family Wellness Centers to contact my insurance on my behalf to verify any chiropractic benefits that may be used. I also agree to be financially responsible for any debts incurred in the case my insurance should deny.

Patient/Guardian Signature: _____ Date: _____

402 Rowland Street Ballston Spa, NY 12020 / Ph: 518-363-0202 / Fax: 518-363-0711