Dr. Gerald K. Edwards, D.C., Q.M.E

Today's Date ____________________ Gender: Male_________ Female_________ Age_____

Patient Name ____________________________ ________________________ ______________

Last First Middle Initial

Address ________________________________ ______________________ _____ ________

Street Address City State Zip Code

Home Tel: ( )____________________________ **Cell Phone: ( )** _________________________

Birthdate ____/____/_____ Social Security #: (req'd) _________-_________-__________

Marital Status: Single___ Married ___ Div ____ Sep _____ Widow ____ Live w/ Partner ____

E-Mail Address ____________________________ Driver License # _________________________

Occupation ____

Employer _______________________________________

Work Address ________________________ ______________________ _____ ________

Street Address City State Zip Code

Work Telephone: ( ) __________________________________ ext:_____________________

Emergency Contact ________________________________ relationship _____________________

Emergency Contact Telephone ( )___________________________

Who referred you to our office? ____

Relation: Doctor____ Attorney _____ Friend _____ Co-Worker_____ Web _____ Other____

Payment/Insurance Info: Cash___ PPO___ Work Comp ___ Personal Injury___ Medicare___ AutoMedPay __

Insurance Company Name ____

Insured's ID/SS# ______________________ Relation to Insured: Self____ Spouse___ Dep ____

Group Number ___________________ Telephone # ( ) ___________________________

Claims Mailing Address ____

Contact/Adjuster Name ____

Claim Number ____________________________ Date of Injury ________________________

Assignment of Benefits/Financial Responsibility: I hereby authorize payment directly to the provider. I understand that my insurance policy is a contract between myself and my insurance company, and having insurance is not guarantee of payment. Deductibles, co-insurances, and non covered services are ultimately my responsibility to pay. The provider will file my insurance claims as a courtesy. I understand that I need to provide at least 24 hours notice when canceling an appointment to avoid a no-show fee. AUTHORIZATION TO RELEASE INFORMATION: I herby authorize the provider to release any of my PHI (personal health information) to process my claim if requested by insurance. Medicare Financial Responsibility: I understand that the Provider as a Medicare Provider is entitled to collect my unfulfilled deductible. The provider accepts assignment for its Medicare patients.

Patient Signature **Date**

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