ORO VALLEY CHIROPRACTIC
10550 N La Canada Dr, Suite 130
Tucson, AZ 85737

Office: (520)-544-2445
FAX: (520)-544-0452

PATIENT INFORMATION SHEET

Name (First, MI, Last)			Age	Date of Birth
Address	City		State	Zip Code
Alternate Mailing Address (residence out of state)	City		State	Zip Code
Home Phone	Cell Phone	E-mail address		
Sex: M F Marital Status: M S W D	Employer		Occupation	

INSURANCE

Primary Insurance (1)	Policy Holder's Name	Policy Holder's Date of Birth
Secondary Insurance (2)	Policy Holder's Name	Policy Holder's Date of Birth

Please provide us with your insurance card(s) and driver's license for identification.

CONTACT PERSON IN CASE OF EMERGENCY

Name	Phone Number:	Relationship

How did you hear about this clinic? _____

Are you here because of an auto accident? _____ Date injured: _____

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The doctor will not be held responsible for any pre-existing medically diagnosed condition. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

Responsible Party Signature:_____ Date:_____