

Family Chiropractic
Dr. John E. Lemon
804.758.1800 / 804.824.7303

General Information

First Name _____
Middle Initial _____
Last Name _____
Suffix _____
Called Name _____
Address _____
City _____
State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____

Sex Male Female
Race American Indian, Alaska Native, Asian,
Black or African America, Native Hawaiian,
Other Pacific Islander, White, Declined to State
Ethnicity Declined to State, Hispanic or Latino,
Not Hispanic or Latino
Language _____
Marital Status Single Married Other _____
Birthdate _____
Social Security _____

Employer Information

Work Status Employed Full-time student Part-time student
Employer Name _____
Address _____

Insured's Information

Patient is the Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex Male Female

Carrier Information

Name _____
Address _____
City, State, Zip _____
Contact _____
Phone _____

For Office Use Only

Account Number _____
Effective Date _____
Calendar Year /Plan Year _____
Yearly Deductible _____
Yearly OOP _____
C/P _____
Manipulation _____
Max Visits _____
Therapy _____
Xray _____
Orthotics _____
Referral/Pre Auth _____
Mailing Address _____
C/S Rep _____
BP: _____
HT: _____ WT: _____

Emergency Contact

Name _____
Phone Number _____
2nd No _____
Relationship to Patient _____

PCP/Family Physician

Name _____
Phone # _____

Condition Information

Related to Employment Yes No
Related to Auto Accident Yes No
Related to Other Accident Yes No

Referred By: Friend Family Internet Phonebook PCP Other

COMPANY NO. 2

Insured's Information

Patient is the _____ Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex _____ Male Female Unknown

Carrier Information

Name/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____
Fax Number _____
Email Address _____
Web Site _____
Payer ID _____
Form Layout _____

COMPANY NO. 3

Insured's Information

Patient is the _____ Same/Self Husband Wife Child Other of Insured
First Name _____
Middle Initial _____
Last Name _____
Address _____
City, State, Zip _____
Phone Number _____
Social Security _____
Date of Birth _____
Sex _____ Male Female Unknown

Carrier Information

Name/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____
Fax Number _____
Email Address _____
Web Site _____
Payer ID _____
Form Layout _____

Plan Information

Plan Name _____
Insurance ID _____
Group No _____
Local Use _____
Benefits Primary Secondary Other
Coordination _____
Claim Type _____
Send Form To _____

Employer Information

Employer/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____

Coverage Information

Coverage Effective Date _____
Coverage Notes _____
Limitations Notes _____

Plan Information

Plan Name _____
Insurance ID _____
Group No _____
Local Use _____
Benefits Primary Secondary Other
Coordination _____
Claim Type _____
Send Form To _____

Employer Information

Employer/Code _____
Attn: _____
Address _____
City, State, Zip _____
Contact _____
Phone _____

Coverage Information

Coverage Effective Date _____
Coverage Notes _____
Limitations Notes _____