Excellence In Health Chiropractic

Dr. William A. Ross, D.C.

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Name:_____ Birth date:_____ SS#:_____
Last First Middle Initial

Address:_____
City State Zip Code

Home Phone: (____)-_____ Cell: (____)-_____ Work: (____)-_____

Email Address:_____ Employer Name:_____ Phone:_____

Name of emergency contact:_____ Phone: (____)-_____

Which number may we call you at to confirm the appointments? HOME CELL WORK

Guarantor Information: If patient is a minor please fill in the following

Name: _____ Relationship to patient:_____

Address: _____
Only if different than our patient

Employer Name:_____ Phone:_____

In order to better serve you please list your primary doctor so that we can request pertinent health information.

Name of primary Doctor:_____ Phone:_____

Whom may we thank for referring you? (Circle one)

Anchorage Daly News Professional (name)_____ PPO List
New Resident letter Family (name)_____ Walk-in/Sign
Yellow Page Friend (name)_____ Other_____

I authorize treatment for the patient named above. I understand that Excellence In Health Chiropractic will assist me in billing my insurance carrier. I also understand and agree that a copy of my insurance card will be given to the clinic. I also understand that my insurance policy is an arrangement between the insurance carrier and me. I understand and agree I am ultimately responsible for the balance of my account for any professional services rendered (regardless of my insurance status). I certify this information is true and correct to the best of my knowledge. I will notify Excellence In Health Chiropractic of any changes in my status or the above information.

Patient signature:_____ Date:_____

Guarantor signature:_____ Date: _____