RYAN CHIROPRACTIC, PLLC

Patient Information

First Name ____________________ **Middle Initial** ___ **Last Name** ___________________________

I prefer to be called by____

Mailing Address ____

City ______________________________ **State** ________________ **Zip Code** ____________

Home Phone (____) _______-____________ **Work Phone** (____) _______-___________

Cell Phone (____) _______-_____________ **Email** ____

Date of Birth _____/_____/______ **Sex**: Male _____ Female _____

Your Preferred method for appointment reminders (circle one): CELL PHONE or **EMAIL**

If you chose Cell Phone, **please list your carrier**: _______________________________________
(ie: Verizon, Sprint, AT&T, T-Mobile, etc…)

Last 4 digits of your primary phone number will be your patient code: ________________

Payment/Insurance Information:

Who is responsible for your bill?

- ☐ Self / Cash
- ☐ Worker's Comp
- ☐ Medicare
- ☐ Health Insurance
- ☐ Auto Ins / No Fault
- ☐ Spouse
- ☐ Other ______________________________

Personal Health Insurance Carrier: ____

Member ID # (include letters) ____

Policy Holder's Name: ____

Policy Holder's Date of Birth _____ / ____ / _____

Primary Care Physician ____

Have you filed an injury report with your employer? Yes _____ No _____

{Please notify the Front Desk Staff if your injury is a result of a work-related injury or auto accident and complete the appropriate paperwork}

How did you hear about us? ____