



Universal Chiropractic & Functional Rehabilitation

2354 MARITIME DRIVE, SUITE 100 ELK GROVE, CA 95758 PH.916.683.3900 FX.916.683.3339

PATIENT INFORMATION

NAME: _____ HOME # (____) _____
ADDRESS: _____ CELL # (____) _____
CITY: _____ STATE _____ ZIP _____ PAGER # (____) _____
SEX: M or F DATE OF BIRTH ___/___/___ AGE: _____ HOME # (____) _____
EMPLOYER / OCCUPATION: _____ SOCIAL # _____
SPOUSE/MATE: _____ DRIVERS LIC. # _____
EMERGENCY CONTACT/RELATIONSHIP: _____ WORK # (____) _____

PLEASE COMPLETE IF PATIENT IS MINOR

RESPONSIBLE PARTY/RELATIONSHIP: _____
ADDRESS: _____ HOME # (____) _____
RESPONSIBLE PARTY EMPLOYER: _____ WORK # (____) _____

PLEASE COMPLETE THIS SECTION FOR INSURANCE

INSURANCE CARRIER: _____ PHONE # (____) _____
ADDRESS: _____
ID# _____ GROUP # _____
NAME OF EMPLOYER IF GROUP HEALTH PLAN _____

INSURANCE AUTHORIZATION & ASSIGNMENT

I hereby authorize my insurance benefits to be paid directly to Brett J. Lemire, DC and authorize the release of any information necessary to process my claim. A copy of this authorization shall be as valid as the original.

SIGNATURE OF PATIENT/AUTHORIZED PERSON

DATE: