

# MAURICIO CHIROPRACTIC EAST, LLC

Diego F Jativa DC

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Date: Home Phone: Email:  
Name:  
Address:  
City: State: Zip Code:  
Date of Birth: Age: Sex: M F Soc Sec :  
Employer: Occupation:  
Work Phone: Cell Phone: Marital Status:  
Emergency Contact: Phone #:  
Whom may we thank for referring you?  
Medical History: Diabetes Heart Disease Epilepsy Pacemaker Strokes  
Primary complaints:

Primary Doctor: Phone #:

## Primary Insurance

Name of Insurance Company:  
Insured Name: Relation to Insured:  
Insured ID#: Group#:

## Additional Insurance

Name of Insurance Company:  
Insured Name: Relation to Insured:  
Insured ID#: Group#:

## Signature on File

- I authorize the use of this form on all my insurance submission.
- I authorize release of information to all my Insurance Companies.
- I understand that I am responsible for any payment due for services rendered.
- I authorize my doctor to act as my agent in helping me obtain payment from my Insurance.
- I authorize payment direct to my doctor.
- I permit a copy of this authorization to be used in place of the original.

**Patient's Signature:**

**Date:**