MAURICIO CHIROPRACTIC WEST, LLC

Diego F Jativa DC
2467 East Semoran Blvd., Apopka, Fl 32703
Tel. (407) 814-0985 Fax. (407) 814-0119

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:** _____