Roth Chiropractic Minneapolis,
21 4th St. NE., Mpls, MN 55413 (612) 916-3506 www.rothchiropractic.net

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Patient's Name: _____ Date of Birth_____
First Middle Last

Address: _____ SS#_____
City State Zip

Home Phone _____ Cell _____

Employer Name _____ Phone_____

Preferred Appointment Reminders: Phone Call ☐ Text ☐ E-Mail ☐ E-mail_____

Primary Language_____ Gender: M ☐ F ☐ Is visit related to an Accident? Work ☐ Car ☐ Other ☐

Ethnicity: Not-Hispanic Yes-Mexican, Mexican American ☐ White ☐ Black or African American ☐ Other_____

SPOUSE/ GUARDIAN_____ Phone _____
First Middle Last

Date of Birth _____ SS# _____ Employer _____

EMERGENCY- Nearest relative or friend not living with you _____

Relation _____ Phone # 1 _____ Phone # 2_____

Insurance and Responsible Party information

Is visit related to an Accident? Work ☐ Car ☐ Other ☐ _____

Primary _____

Group #: _____

Policy #: _____

Social Security #: _____-_____-_____

Address _____

City_____

State _____Zip _____

Phone _____

Responsible Party's Name (if other than patient)

_____

Male ☐ Female ☐ What is the Relationship to Patient

Self ☐ Spouse ☐ Child ☐ Other _____

DOB: _____/_____/_____

Secondary_____

Group #: _____

Policy #: _____

Social Security #: _____-_____-_____

Address _____

City_____

State _____Zip _____

Phone _____

Responsible Party's Name (if other than patient)

_____

Male ☐ Female ☐ What is the Relationship to Patient?

Self ☐ Spouse ☐ Child ☐ Other _____

DOB: _____/_____/_____

I have received a copy of the Notice of Privacy Practices. I understand fully the above information: I authorize and request my insurance company to pay any health benefits directly to the above provider resulting from care received in that facility. I furthermore give my consent to release my Medical records to resolve claims for services.

Signature _____ *Date*_____