Patient Information Form
McCracken Chiropractic & Wellness Center
284 Central Way
Kirkland, WA 98033

Today's Date: ____/____/_____

Name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Home Phone: (____) ____-_____ Cell/Work Phone: (____) ____-_____

Social Security Number: _____-____-_____ Date of Birth: ____/____/_____

Marital Status:
- □ Married
- □ Single
- □ Widowed
- □ Divorced
- □ Separated

Employer: _____ Occupation: _____

Employer Address: _____
_____

Name of Spouse: _____

Spouse Employer: _____ Occupation: _____

Number of Children: ____ Name(s)/Age(s): _____

Referred to our office by: _____

Insurance Information:
(Please present your insurance card when returning this form and we'll do the rest for you!)

Assignment of Benefits: hereby assign and grant the benefits that I am eligible to receive for professional services rendered in this office to McCracken Chiropractic. I authorize the release of any medical information necessary to process any insurance claims for payment. I understand that I am financially responsible for those charges not paid by my insurance.

_____ _____/_____/_____
Patient's Signature (Guardian if minor) Date