PATIENT INTAKE FORM

Dr Scott Selby, LLC
207 N. Washington Street
Wheaton IL 60187

DR. SCOTT SELBY
Chiropractic Physician

PATIENT INFORMATION ❑ **New Patient** ❑ **Established PT**

Patient's FIRST Name: MIDDLE: LAST:				Social Security #:	
Birth date: / /	Sex: ❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid	Employment Status (circle one) Employed / Retired / Student / Not-Employed	Employer Name:	
Your Address:		City		State:	Zip Code:
Race: ❑Decline ❑White ❑American Indian /Alaska Nat. ❑Asian ❑Black/African American ❑Nat.Hawaii/Oth Pac Islander ❑Other		Ethnic Group: ❑Non-Hispanic ❑Hispanic/Latino ❑Decline		Language: ❑English ❑Spanish ❑Other:_____	
Primary Phone#: ❑ Cell ❑ Work ❑Home ( )		Alternate Phone#: ❑ Cell ❑ Work ❑Home ( )		Email Address: Appointment reminder by email? ❑ Yes ❑ No	
Referring Physician Name:		How did you hear about our office?			
Primary Physician Name:		Reason for visit:	Date of Inj/Onset:		

RESPONSIBLE PARTY:

Person Financially Responsible [Guarantor] ❑ Self Only→Skip to insurance section ❑ Other Guarantor→Complete this section	Guarantor's Full Name:		Patient's Relationship to Guarantor: ❑ Child ❑ Spouse ❑ Other:
Address (if different):		Birth date: / /	Social Security #:

INSURANCE INFORMATION:

Primary Insurance Company Name:	Plan Name:	Type of Plan: ❑ PPO ❑ POS ❑ HMO ❑ Medicaid ❑ Medicare ❑Tricare ❑ Medicare HMO ❑ WC ❑ Lien		
Claims Address:			Phone#: ( )	
Policy#:	Group #:	Group Name:		
COPAY: $	Annual Deductible: $ ❑ Met ❑ Not Met ❑ Don't Know	Coinsurance: ❑ None (Plan pays 100%) ❑ 80/20 ❑ 90/10 ❑ 70/10 ❑ Don't Know	Effective Date: / /	
Is plan thru employer? ❑ No ❑ Yes	Employer address:		Occupation:	
Secondary Insurance Company Name:	Plan Name:	Type of Plan: ❑ Medicare Supplemental ❑ Medicaid ❑ Other Employer/Commercial ❑ Spouse's Plan (Pls. complete guarantor section) ❑ Other:		
Claims Address:			Phone#: ( )	
Policy#:	Group #:	Group Name:		
Is plan thru employer? ❑ No ❑ Yes	Employer Name & Address:			

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to Dr. Scott Selby, LLC as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Patient/Guardian signature: _____ Date _____