FREEDMAN CHIROPRACTIC CENTER, LLC

CONFIDENTIAL PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____ **Age** _____

If you are suffering from a condition, what was the cause:

_____

_____

_____

OR

_____ **Presently, I am not suffering from pain nor have a condition. I want to ensure that my body is functioning at its best, so I can be healthier and have stronger immunity**

WOULD YOU LIKE TO FIND OUT ABOUT YOUR INSURANCE COVERAGE? IF SO, PLEASE COMPLETE THE INSURANCE INFORMATION BELOW. WE WILL CONTACT YOUR INSURANCE CARRIER AND ADVISE YOU WHAT BENEFITS ARE AVAILABLE.

CONFIDENTIAL INSURANCE INFORMATION

Insurance carrier:_____

Policy Holder's Name:_____ **Policy Holder's date of birth:** _____

Policy Holder's employer:_____ **Policy/ID#:** _____

Policy Holder's SSN:_____ **Group#:**_____

Insurance Company Provider's Phone #: _____ - _____ - _____

Insurance Company Phone #: _____ - _____ - _____ **(if no provider contact information is given)**