WELCOME
to
Luedtke-Storm-Mackey Chiropractic Clinic

Date____________

Dr

Patient Information

Last Name___________________________________ First Name________________________ Middle Initial_________

Street Address________________________________ City ___________________________ State______ Zip_________

Home Phone_________________ Work/Day Phone________________ Ext__________ Cell Phone_________________

Social Security #_________________________ ☐ Female ☐ Male Birthdate __________________ Age ________

Marital Status ☐ Married ☐ Single E-mail ___________________________ Occupation _____________________

Employer's Name & Address____

Preferred Language ☐ English ☐ Other (please indicate)__________________________ Race __________________

Driver's License #______________________________ How did you hear about us?______________________________

Spouse Information (if applicable)

Spouse's Last Name______________________________ First Name _______________________Middle Initial_________

Spouse's Birthdate__________________________ Social Security #____

Spouse's Occupation___________________________________ Employer Name___________________________________

Employer Address (City, State Zip)____

Has this person been a patient in one of our clinics? Yes No

Emergency Contact Information

Last Name______________________________________ First Name________________________ Middle Initial_________

Relationship to you______________________________ Phone ____________________ Alt Phone___________________

Parent/Guardian Information (if applicable)

Parent/Guardian____ Relationship to Patient_________________________

Full Address (if different from patient)____

Phone Number____________________ Birthdate______________ Social Security Number_________________________

Has this person been a patient in one of our clinics? Yes No

Injury Information

Were you injured at work? (Are you filing a worker's compensation claim?) Yes No

Were you in an auto or other accident? (Are you filing a third party accident claim?) Yes No

Insurance Information

Primary Ins Carrier_________________________________

Policyholder's Name_______________________________

Subscriber Number_________________________________

Group Number_____________________________________

Relationship to Patient_____________________________

Policyholder's Birthdate____________________________

Secondary Ins Carrier_________________________________

Policyholder's Name__________________________________

Subscriber Number___________________________________

Group Number_______________________________________

Relationship to Patient________________________________

Policyholder's Birthdate_______________________________

I request LSM to file to my insurance (if applicable); therefore, I hereby authorize release of any information necessary to process my claim. I understand that regardless of insurance, I am responsible for services/items not covered by insurance. I further authorize direct payment of my benefits to LSM Clinic.

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Patient or Parent Signature if Patient is a Minor Relationship (if applicable) Date