



Falanga Family Chiropractic
4 Butternut Drive
Oswego, NY 13126
315 343-2961
315 343-4001 fax

PATIENT INFORMATION UPDATE

Please PRINT

Patient's Name (Last, First M.I.) _____

Address: _____

City - State - Zip: _____

Phone Number (Home) _____ (Work) _____ (Cell) _____

Social Security #: _____ Date of Birth: _____

Marital Status: Single Married Divorced Widowed Other

Gender: Male Female

Emergency Contact Person: _____ Relationship to You: _____

Emergency Contact Phone #: _____

Current Employer: _____

Employer's Address: _____

City - State - Zip: _____

Job Description/Title: _____ Supervisor: _____

Current Work Status: Full Duty Modified Duty Not Working Unemployed

1) Did your injuries result from your employment? Yes No Date: _____

2) Did your injuries result from a motor vehicle accident? Yes No Date: _____

3) Did your injuries result from a "slip or fall"? Yes No Date: _____

4) Are your injuries the result of a medical condition? Yes No

If you answered "YES" to question #1, #2 OR #3 - Please provide the date your accident occurred: _____

Primary Health Insurance

Name of Carrier: _____ Subscriber: _____

Address: _____ Subscriber's ID#: _____

Subscriber's Group #: _____

City - State - Zip: _____ Subscriber's Date of Birth: _____

Phone Number: _____ Subscriber's Soc Sec #: _____

Secondary Health Insurance (if applicable)

Name of Carrier: _____ Subscriber: _____

Address: _____ Subscriber's ID#: _____

Subscriber's Group #: _____

City - State - Zip: _____ Subscriber's Date of Birth: _____

Phone Number: _____ Subscriber's Soc Sec #: _____

(Your) Motor Vehicle Insurance (if applicable)

Name of Carrier: _____ Insured: _____

Address: _____ City - State - Zip: _____

Policy #: _____ Claim #: _____

Phone Number: _____ Adjuster's Name: _____

Worker's Compensation Insurance (if applicable)

Name of Carrier: _____ Insured: _____

Address: _____ City - State - Zip: _____

Policy #: _____ Claim #: _____

Phone Number: _____ Adjuster's Name: _____

If Applicable, Please Complete Your Attorney Information

Name of Attorney: _____

Attorney's Address: _____

City - State - Zip: _____

Attorney's Phone #: _____ Attorney's Fax #: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize Falanga Family Chiropractic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to Falanga Family Chiropractic insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient (or parent if a minor) _____ Date _____