POLAR FAMILY CHIROPRACTIC CENTER

Donald R. Mandel, D.C.
2470 N McKnight Rd North St. Paul, MN 55109
(651) 777-3877 Fax (651) 773-0708

PERSONAL INFORMATION

Date: _____ Acct. #: _____ Dr._____ Driver's License #: _____

Name: _____ Social security #: _____

Address: _____
Street/house number city state zip code

Home phone: _____ May we call you at home? ( ) Yes ( ) No

Email address: _____ May we put you on our emailing list? ( ) Yes ( ) No

Birth date: _____ Gender: M F Height: _____ Weight: _____

Name of employer: _____ Occupation: _____

Business Address: _____
Street/building number city state zip code

Business phone #: _____ May we call you at work? ( ) Yes ( ) No

CIRCLE ONE: Single Married Widowed Separated Divorced

Name of significant other:_____

Significant other's employer: _____Wk Phone:_____

Childrens' names: _____

Name and phone number of person to contact in case of emergency:

_____
name phone #

How were you referred to our office? _____

INSURANCE/BILLING INFORMATION

Do you have insurance you want to apply toward your Chiropractic charges? YES NO

Primary Insurance _____ Secondary Insurance_____
If yes, please present your insurance card(s) to the front desk for copying to place in your file. Polar Family Chiropractic Center is a BCBS Aware Provider ONLY. All other insurance would be out of network—we will be happy to verify your coverage in either case.

EVEN THOUGH YOU MAY HAVE SOME INSURANCE COVERAGE, YOU ARE TOTALLY RESPONSIBLE FOR ALL CHARGES INCURRED DURING THE DURATION OF YOUR TREATMENT AT POLAR FAMILY CHIROPRACTIC CENTER.

PLEASE READ AND SIGN THE FOLLOWING ASSIGNMENT OF BENEFITS AND MEDICAL RECORDS RELEASE.

1. I am instructed to pay directly to the doctor at Polar Family Chiropractic Center, 2470 N McKnight Rd, North St. Paul, Minnesota 55109, for all professional services rendered to me by said office.
2. This instruction to Polar Family Chiropractic Center is an assignment of my right under medical coverage.
3. Any sum of money paid under this assignment shall be credited to my account and I shall be personally liable for any unpaid balance to the doctor. Additionally, I am personally liable for any unpaid accounts for diagnostic and consultant services.
4. My signature also will authorize release of medical records, if requested by my insurance company named above.

Patient name: _____Date:_____

Signature (Parent if minor): _____