Welcome To Our Office

Please Print and Complete ALL Sections

Today's Date: _____ Office Account: _____

Better Health, DC, MD.
Michael L. Malmgren, D.C., P.A.
Elane Shirar, off-site Medical Director

Patient's Information:

Name (First) _____ (Last) _____ Marital Status: _____ Gender: M / F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____

Employment Status: Full-Time / Part-Time / Not Employed Occupation _____ Student: Yes / No

Date of Birth _____ Age _____ Social Security Number _____

Guarantor's Information (if patient is a minor) or Personal Representative:

Name _____ Marital Status: _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____

Occupation _____ Date of Birth _____ Age _____ Social Security # _____

Whom may we thank for referring you? _____

Insurance (Please complete thoroughly. We need to copy your insurance card and picture identification.)

Do you have health insurance: Yes / No

Primary Insurance	Secondary Insurance
Address	Address
Phone	Phone
Primary Insured Person	Primary Insured Person
Primary Person's Date of Birth	Primary Person's Date of Birth
Primary Person's Social Security #	Primary Person's Social Security #
ID/Policy # Suffix	ID/Policy # Suffix
Group #	Group#

Accident: No / Auto / Work Related / Other: _____

Date of Injury _____ Liability Carrier _____ Claim # _____

Are you represented by an attorney? Yes / No Name: _____

Nearest Relative Not Living With You:

Name _____ Address _____

Relationship _____ Home Phone _____ Work Phone _____

Insurance Benefits Authorization:

I hereby authorize payment to Better Health, DC, MD. named above of the applicable policy benefits otherwise payable to me, but not to exceed the charges. I understand that I am financially responsible to the doctor for charges not covered by this assignment; I agree to pay court costs, interest charges up to 18% and attorney fees in the event that my account is turned over to a collector for any reason, including absence of office referrals and treatment preauthorizations. I authorize release of my records to my insurance company to process my claim.

_____ _____

Patient (or representative) Signature Date