

Dr. Landon Kirk
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Diagnosis: _____

PATIENT REGISTRATION & INSURANCE VERIFICATION

Patient's Name _____ D.O.B. _____ Sex: []M []F

Street _____ Apt _____ City _____ State _____ Zip _____

Patient SS# _____ Patient Phone () _____ E-mail _____

Patient's Employer _____ Work Phone () _____

Insured's Name _____ D.O.B. _____ Phone () _____

Insured's Address _____ City _____ State _____ Zip _____

Insured's Employer _____ Insured's SS# _____

Work Phone () _____

How did you learn about us? _____

PRIMARY INSURANCE

SECONDARY INSURANCE

Company _____ Company _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Phone () _____ Phone () _____

Policy# _____ Group# _____ Policy# _____ Group# _____

Insured's Name _____ Insured's Name _____

Relationship: [] Self; [] Spouse; [] Child

Relationship: [] Self; [] Spouse; [] Child

IF THIS IS A MEDICARE PATIENT, PLEASE COMPLETE

Date of Initial Visit _____ Date of Last X-ray _____

CHECK IF THIS IS AN [] AUTO; [] WORKER'S COMP; [] PERSONAL INJURY & COMPLETE:

Date of Accident or Injury _____ Claim# _____

Adjuster's Name _____ Phone# () _____

Address _____ City _____ State _____ Zip _____

Attorney's Name _____ Phone# () _____

Address _____ City _____ State _____ Zip _____

Patient's Signature _____ Date _____