Patient Name: _____ Date: _____

Morgan Chiropractic, Inc.
Patient Information Update Form

PATIENT INFORMATION

Patient Last Name:		First:	Middle:	Marital Status (circle one) Single/Married/Divorced/Widowed/Other	
Date of Birth: ___/___/_____	Sex: M / F	Social Security Number:	Phone Number:	Email Address:	
Address:			City:	State:	Zip Code:
Employer:		Job Title:		Secondary Phone Number:	

INSURANCE INFORMATION (If your insurance changed, please have the front desk scan your Insurance card(s))

Will you be using insurance for your visits? ___Yes ___No (if no, please skip this section)		
Primary Insurance Company:	Subscriber Name:	
Secondary Insurance Company:	Subscriber Name:	
AUTO INCIDENT Insurance Name:	Claim Number:	Claim Adjuster (if you know):

SIGNATURE

In exchange for Morgan Chiropractic, Inc.'s forbearance from collecting all amounts owed by me for services rendered at the time of the provision of service, I hereby assign my rights to the clinic as follows: I understand and agree that health and accident insurance policies are an arrangement between an insurance company or carrier and myself. Furthermore, I understand that the clinic will prepare any necessary reports and forms provided by me to assist me, or my legal representative, in making collection from the insurance company or carrier. I hereby specifically authorize the release of any information concerning me to my insurance carriers, insurance carriers of persons or entities responsible for my injuries, my employer, claims adjustors responsible for claims filed by me, administrative agencies, the Alaska Workers' Compensation Board, and my attorneys. To the extent of my unpaid bill to the clinic, I hereby irrevocably assign to said clinic on behalf of myself, my heirs and beneficiaries any interest that I might have now or in the future to any cause of action or claim, whether legal or administrative, and direct my legal representative that at the time of final judgement, and final disposition or settlement this assignment shall have priority over all others not entitled by law to superior priority.

I specifically request that any amount authorized to be paid to me by an insurance company, employer, or legal representative shall be paid directly to the clinic, and will be credited to my account upon receipt. If the payment is insufficient to pay for all my indebtedness, I will remain liable to Morgan Chiropractic, Inc. for the balance, including finance charges and collection expenses.

I clearly understand and agree that all services rendered to me, whether I have health or accident insurance coverage or not, and that I am personally responsible for payment and, unless arrangements are otherwise made, said payments are immediately due and payable at time of visit. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. In such event, I agree that this assignment will remain effective until all sums I owe Morgan Chiropractic, Inc. are fully paid.

Patient or Guardian Signature:	Date:

Morgan Chiropractic Inc.
11260 Old Seward Hwy Suite 106
Anchorage, AK 99515
(907) 646-2211

Adjusting to a Healthier Life

MCI

Morgan Chiropractic, Inc.

Patient Name: _____ Date: _____

Current Complaints		
Briefly describe your current injury/condition:		
Date of Injury/condition: _____/_____/_____	Date Symptoms Appeared: _____/_____/_____	
Is this a new injury/condition? ____ Yes ____ No	If Yes, When?	
List of Practitioners seen for this injury/condition:		
Area of Pain:	Pain Level: ____/10	Aching/Burning/Stabbing/Numbness/Other
Area of Pain:	Pain Level: ____/10	Aching/Burning/Stabbing/Numbness/Other
Area of Pain:	Pain Level: ____/10	Aching/Burning/Stabbing/Numbness/Other
Area of Pain:	Pain Level: ____/10	Aching/Burning/Stabbing/Numbness/Other
Area of Pain:	Pain Level: ____/10	Aching/Burning/Stabbing/Numbness/Other
Area of Pain:	Pain Level: ____/10	Aching/Burning/Stabbing/Numbness/Other
Any Notes for the Doctor:		

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