John Zimmerman, D.C.

2629 Redwing Road Suite 200 . Fort Collins Colorado 80526
Phone (970)672-0789 . Fax (970)672-0884

PATIENT INTAKE FORM **Today's Date:_____**

Please fill out all information completely. This is a requirement, prior to being seen for your appointment.

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Initial:_____
Date of Birth:_____ Sex: [ ] M or [ ] F E-mail Address:_____
Mailing Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

EMERGENCY CONTACT INFORMATION

Contact Name:_____ Relationship:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

RESPONSIBLE PARTY (legal guardian information – IF PATIENT IS A MINOR)

Last Name:_____ First Name:_____ Middle Initial:___ Date of Birth:_____ Sex: [ ] M or [ ] F
Mailing Address:_____ State:_____ Zip Code:_____

BILLING INFORMATION (Who are we billing for you?)

Please choose one of the following options:

Self Pay [ ] Insurance or Medicare [ ] Work Comp [ ] Motor Vehicle Accident [ ]

Insurance Company Name:_____ ID#_____ GRP#_____

IS THE PATIENT THE POLICEY HOLDER OF THE INSURANCE? YES [ ] OR NO [ ]
(If you selected **NO**, complete the policy holder information section below)

POLICY HOLDER INFORMATION (If the patient is NOT the policy holder)

Last Name:_____ First Name:_____ Middle Initial:_____
Date of Birth:_____ Sex: [ ] M or [ ] F E-mail Address:_____
Mailing Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

(If we are billing insurance we require a copy of the card, in addition to the other information provided)