ACTIVE SPINE & SPORTS CARE
CHIROPRACTIC · WELLNESS

2370 Las Posas Rd., Ste B
Camarillo, CA 93010
(805) 384-0101

Patient Information

Date: _____ / _____ / _____ **SSN:** _____ - _____ - _____ **Date of Birth:** _____ / _____ / _____

Name (First, Last): _____

Address: _____ **City:** _____

State: _____ **Zip:** _____ **Email:** _____

Home: _____ **Cell:** _____ **Work:** _____

Gender: Male Female **Marital Status:** Single Married Divorced Widowed

Emergency Contact

Name: _____ Phone: _____ Relation: _____

Who May we THANK for referring you? _____

We will send you a reminder 1 day prior to your future appointments, how would you prefer to receive them?
(Please CHOOSE ONE): E-mail OR Text

OFFICE USE ONLY:

Height: _____ Weight: _____ BP: _____ / _____ HR: _____

Check box if applicable:

- ☐ **Pregnant**
- ☐ **Pacemaker**
- ☐ **Heart condition**
- ☐ **other: _____**

Are we billing insurance? ☐ Yes - Please fill out insurance info ☐ No - Please skip next section

Insurance Information

Primary Carrier: _____ Member ID: _____

Secondary Carrier: _____ Member ID: _____

Is your injury/illness WORK related? Yes No Date of Injury: _____ /_____ /_____

Is your injury/Illness related to an AUTOMOBILE ACCIDENT? **Yes** **No** Date of Accident: _____ /_____ /_____

Insurance Carrier: _____ Claim #: _____

Claim Adjuster: _____ Phone: _____ Ext. _____

ASSIGNMENT AND RELEASE

I, the undersigned assign directly to Dimaano Chiropractic, Inc./Romeo E. Dimaano, D.C./Casey Scott- Deeb, LAc all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Romeo E. Dimaano, D.C./ Casey Scott- Deeb, LAc to release all information necessary to secure the payment of benefits. I authorize the use if this signature on all insurance submissions and/or requests pertaining to my physical condition, including, but not limited to, all records, reports, progress notes, reports of diagnostic tests, x-rays and or medical opinion.

Responsible Party Signature: _____ Relationship: _____