Wunderlich Chiropractic Clinic, P.A

Dr. Chance Wunderlich
1402 Lafayette Street – Cape Coral, FL 33904 – (239) 540-9888

Patient Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Work Phone: _____

Social Security #: _____ Preferred method of contact: _____

Date of Birth: _____ Email: _____

Occupation: _____ Employer: _____

Referred By: _____ Primary Insurance: _____

Age: _____ Marital Status: M S W D ID# _____

What is your health goal in our office? _____ Secondary Insurance: _____

_____ ID# _____

Name of Insured: _____ DOB: _____ Relationship: _____

Person to contact in case of emergency (Name and Phone): _____

Chief Complaint: _____

Pain Scale

☺	0 1 2 3 4 5 6 7 8 9 10	☹	Part of the time	Half of the time	Most of the time	All of the time

Other Complaint: _____

Pain Scale

☺	0 1 2 3 4 5 6 7 8 9 10	☹	Part of the time	Half of the time	Most of the time	All of the time

Other Complaint: _____

Pain Scale

☺	0 1 2 3 4 5 6 7 8 9 10	☹	Part of the time	Half of the time	Most of the time	All of the time

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Wunderlich Chiropractic Clinic, P.A. all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator orf fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with the doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action, or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

I understand that there will be no fees charged if I give 24 hours' notice to cancel or reschedule an appointment.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured/Guardian Date