Balanced Body
CHIROPRACTIC MN, P.A.

Dr. Jen Skelton, DC, CVSMT Phone # 952-807-5397 Fax: 952-452-8334
10740 Lyndale Ave S., Suite 18E, Bloomington, MN 55420
E-mail: drjen@balancedbodymn.com Website: www.balancedbodymn.com

Health Information

Patient Name:____ Date ___________

Preferred name / nickname _____________________________ Gender: Male Female

Marital Status: (Circle one) M S D W Other: ______________ Date of Birth ___/___/___

Spouse Name: ____________________________________ How many children: _____

Patient Social Security Number: _________-_________-_________

Patient Address: __________________________________ City _______________ State____________ Zip Code: __________

Phone Number: ______-______-_______ Cellular Number: ______-______-_______

Email: _______________________________ Work Phone ______-______-_______

Employer: _______________________ Occupation: ______________________

How did you hear about us? ____

Referred By: ____________________________

Emergency Contact ___________________________ Phone______-______-_______

Is this condition due to: Auto Accident Personal Injury Work Related Accident?

Do you have health insurance? Yes No

Do you have more than one insurance? Yes No

Name of Insurance Company: __________________________ID #_______________

Is your spouse employed? Yes No

Is your spouse the primary insured? Yes No

Are you covered by Medicare? Yes No

I hereby state that the information on this form is true and correct. I authorize Balanced Body Chiropractic MN, P.A. to examine, treat, and do whatever they deem necessary in accordance with the state statutes, for the care and management of my condition. I clearly understand and agree that all services administered to me, including services that are not preauthorized, or are not covered by the 3ed party payor, for any reason, are my responsibility and that I will pay for all services rendered to me at Balanced Body Chiropractic MN, P.A.. I understand and agree that health and insurance policies are an arrangement between an insurance carrier and myself. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all co-payments and non-covered services. 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.

I hereby authorize the release of my health evaluation, examination, prognosis and treatment records, to my employer, attorney, insurance company, and/or family physician.

Patient's Signature ____ Date ____________