

GEORGIA CHIROPRACTIC ASSOCIATES
Dr. Craig Steingraber
Board Eligible, American Chiropractic Neurology Board
Certified Chiropractic Sports Practitioner

Patient Name: _____
Date of Birth: _____ Sex (please circle): M/F SS#: _____
Address (street/city/state/zip): _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Email: _____

Insured's Name: _____
Insured's Date of Birth: _____ Insured's Sex (please circle): Male/Female
Insured's Address: _____
Insured's Home Phone: _____ Insured's Date of Birth: _____
Do you wish for us to directly bill your insurance? (circle which applies): Yes-No

Insured's Insurance Name: _____
Insurance ID#: _____ Insurance Phone#: _____
Insurance Group#: _____ Employer's Name: _____

If there is additional insurance coverage, please fill out below.

Other Insurance Name: _____
Other Insurance ID#: _____ Other Insurance Phone#: _____
Other Insurance Group#: _____ Other Insured's Date of Birth: _____

Patient Relationship to Insured (please circle): self-spouse-child-other
Patient Status (circle which apply): single-married-other-employed-student
Is condition related to (circle which apply): employment-auto accident-other accident
Date current condition occurred: _____
If patient had same or similar condition before, give first date occurred: _____
Dates unable to work due to current condition: from _____ to _____

AUTHORIZATION AND ASSIGNMENT

In consideration of health care services to be rendered by Georgia Chiropractic Associates, LLC, I hereby authorize direct payment to Georgia Chiropractic Associates and/or Craig Steingraber, D.C. Payment will be for charges related only to health care services I authorized to be provided by Georgia Chiropractic Associates and/or Craig Steingraber, D.C. Direct payment authorization applies to any insurance company, attorney's office or other entity which is either proved liable or contracted with to pay for services rendered by Georgia Chiropractic Associates and/or Craig Steingraber, D.C. I understand that as the patient, I am ultimately liable for all charges rendered by Georgia Chiropractic Associates and/or Craig Steingraber, D.C. that are not precluded by insurance contracts by Georgia Chiropractic Associates and/or Craig Steingraber, D.C.

Insurance Name and/or Attorney/Law Firm Name

Patient Signature

GCA/Witness

Date: _____