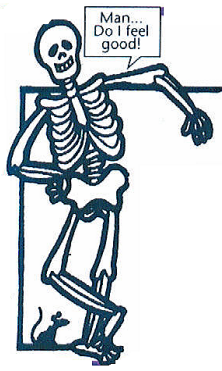

Dr. Lynda L. Purdy Chiropractic Physician

248 3rd Ave. E. 406-755-1113
Kalispell, MT 59901-4532 FAX: 406-260-4021

CONFIDENTIAL PATIENT INFORMATION

Name (first, middle initial, last)_____ Birth Date_____ Gender ____M____F
Address (mail) _____ City, State: _____ Zip: _____
Home Phone _____ Cell _____ Work Phone _____
E-mail address _____ FAX: _____
Who referred you or how did you find Dr. Lynda L. Purdy? _____
What nationality are you (certain medical conditions are associated with ethnicity) _____
Employment status: ____ Full time ____Part time ____Student ____ Retired ___ Disabled ____
Employer: _____ Last Job Title: _____
Social security # _____
Emergency contact _____relationship _____phone: _____
If patient is a minor, name of responsible adult. _____ Relationship_____
Marital Status: ___ Single ___Married (spouse's name) _____ __ ***Recently*** divorced/widowed

Is this condition or problem the result of an accident? ___ yes ___ no ___ yes but claim is closed
Type of accident: (circle one) car accident, fall, work related injury, sports injury, other _____
If yes, complete the following: Date of injury ___/___/___ Claim # _____
Full Billing address for claim: _____
If a work injury: employer at the time of injury: _____ Employer's phone # _____
If you have an attorney what is the name of the law firm _____ Phone # _____

Do you live in public housing or homeless if yes circle which one_____
By signing here I am allowing treatment: _____

WE ACCEPT PAYMENT BY CASH, CHECK, VISA, MC, DISC, & AMEX

Payment for the uninsured, co-pay and deductible is expected at the time of service.

Insurance billing information

WE MUST HAVE THE FOLLOWING IN ORDER TO BILL YOUR INSURANCE COMPANY
If you have a card we can copy it and only complete * in the section below.

Insurance company name: _____ Phone: _____
Claims Address: _____ Plan name _____
City, State: _____ Zip: _____***Name of insured person**: _____
***Your relationship to insured**: _____ ***Insured's ID #:** _____
***Insured's birth date**: _____ ***Employer**: _____
Group or claim #: _____ Policy #: _____

I agree to allow Caring Chiropractic to furnish to the insured's insurance company and/or my attorney all the information which said insurance company or attorney may request concerning my present claim. I hereby assign to Caring Chiropractic, Inc all money to which I am entitled to for expenses relative to the services performed from time to time but not to exceed my indebtedness to Caring Chiropractic, Inc.

_____ _____
SIGNATURE **DATE**