PATIENT DEMOGRAPHIC UPDATE FORM

Date of reported change:

Getting your information to the office

Associates in Family Chiropractic and Natural Health Care

EMAIL: NORWALKDRX@YAHOO.COM	Send this form to the office directly
FAX: 203.838.7623	Send this form to the office
PHONE: 203.838.1555	Call the office to report changes

PATIENT NAME: ____

DOB: ____________________ MARITAL STATUS: ___________________

ADDRESS: ____

CITY: ______________ STATE: ________________ ZIP CODE: _________

DATE CHANGED: _____________________

BEST CONTACT NUMBER: ______________________________________

PREFERABLY A CELL PHONE FOR TEXT APPOINTMENT REMINDERS

E-MAIL: ____

INSURANCE COMPANY: ____

POLICY NUMBER: _________________ GROUP NUMBER: _______________

SUBSCRIBER NAME: _____________________________ DOB: __________

PLEASE ATTACH
A COPY OF THE FRONT AND BACK OF YOUR NEW INSURANCE CARD.

OTHER FAMILY MEMEBRS THESE CHANGES APPLY TO:

NAME: _______________________________ DOB: _________________

NAME: _______________________________ DOB: _________________

NAME: _______________________________ DOB: _________________

NAME: _______________________________ DOB: _________________

ADDITIONAL CHANGES THAT NEED TO BE UPDATED: ____________________

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To update your Payment Method on file, please see page 2.
Complete this form if you need to update your credit card, debit card, HSA, or FSA.

PATIENT DEMOGRAPHICS UPDATE

Associates in Family Chiropractic 156 East Ave, Norwalk CT 06851 T:203.838.1555 F:203.838.7623

THIS FORM IS REQUIRED AND WILL BE DESTROYED ONCE SECURILY ENTERED. THANK YOU!

CREDIT CARD PRE-AUTHORIZATION FORM

Associates in Family Chiropractic
And Natural Health Care, P. C.
156 East Avenue
Norwalk, CT 06851
(203) 838-1555

Patient Name: ____

I authorize Associates in Family Chiropractic and Natural Health Care to charge my credit card account for the following:

- Past Services
- Recurring Payments for Ongoing Care
- Outstanding Balances
- Missed Appointment Fees

The card on file may also be used for your convenience. For example, the need may arise to make a payment or purchase supplements yet, the form of payment was left at home, we could conveniently charge the card on file upon your request.

No charge will be made to your card if you pay on, or prior to your Date of Service. Understand that all outstanding balances is your responsibility.

____ MASTERCARD ____DISCOVER ____ VISA

CARDHOLDER'S NAME ____
(INCLUDE MIDDLE INITIAL IF ON THE CARD)

BILLING ADDRESS ____

____

CREDIT CARD NUMBER ____ EXP __________

CVV______________ PATIENT'S TELEPHONE NUMBER _________________________

I understand that this form is valid for one year unless I cancel authorization with written notice. I also authorize my balance to be charged to this card in full if care is terminated for 30 days or longer for any reason. I also understand that I am only paying for services rendered and will not be liable for services not rendered if I discontinue care for any reason.

CARDHOLDER SIGNATURE ____ DATE ____________

INCLUDE EMAIL ADDRESS IF YOU WOULD LIKE AN EMAILED RECEIPT FOR ANY TRANSACTION.

EMAIL ADDRESS____