CUNNINGHAM CHIROPRACTIC, P.C.
210 Old Bridge Street
East Syracuse, N.Y. 13057

REACTIVATION/ NEW PROBLEM FORM

Name: _____ D.O.B_____/____/_____☐ Male ☐ Female
SSN: _____/____/_____ (REQUIRED) ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address: _____ City: _____ State: _____ Zip: _____

Phone#:(_____)-_____ Cell: (_____)-_____ Work: (_____)-_____

Employer: _____ Address: _____ City: _____ State: _____

Zip: _____ Occupation: _____ Are you working now? ☐ Yes ☐ No ☐ Full time ☐ Part time

Appointment Reminders? ☐Yes ☐No Cell Phone Carrier: ☐ Verizon ☐ AT&T ☐ T-Mobile ☐ Cricket ☐ Other _____
Statements Emailed? ☐Yes ☐No Email:_____

What is your main Complaint? _____

Is this a new injury/condition? ☐ Yes ☐ No….If yes please describe _____

Are there any changes in your health history? ☐ Yes ☐ No if yes, _____

Would you like Cunningham Chiropractic's office to send notes to another provider: ☐ Yes ☐ No if yes, Name & address of Doctor: _____

Consent to Communicate Information to an Authorized Person
This allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with Cunningham Chiropractic, P.C. This form when signed allows Cunningham Chiropractic, P.C. to speak to this authorized person about your personal information concerning insurance benefits, payments, treatment, appointments or any other health care information regarding your care. I _____ (your name) hereby give my consent for Cunningham Chiropractic, P.C. to communicate personal information on my behalf to the authorized person(s) named below. I may revoke this authorization at any time in writing to Cunningham Chiropractic, P.C. 210 Old Bridge Street East Syracuse NY 13057. This authorization allows Cunningham Chiropractic, P.C. to speak with the authorized person(s) regarding: Treatment, appointments, insurance benefits, copays or any other aspects regarding care.

Signature: _____ Date: _____

Person(s) Authorized to speak with Cunningham Chiropractic, P.C.
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Primary Insurance Co Name: _____ Member ID/Claim#_____
Who is the subscriber? _____Their DOB: ____/____/_____ Group#: _____

Second Insurance Co Name: _____ Member ID/Claim#_____
Who is the subscriber? _____Their DOB: ____/____/_____ Group#: _____

INSURANCE POLICY

I the undersigned certify that I (or my dependent) assign directly to Cunningham Chiropractic, P.C. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any copayments, deductibles, coinsurance or any other amounts whether or not paid by insurance. I also understand that Cunningham Chiropractic, P.C. does not participate with Medicaid and agree to pay for any deductibles, copayments or coinsurance not payable by my insurance. I also understand that I am responsible for any and all collection fees, if the account goes to collections. I authorize the use of my signature on all insurance submissions. I also understand a quote of benefits does not guarantee payment. Payment of insurance benefits are subject to terms, limitations, and the plan exclusions at the time services are render.

_____ _____
Name: Signature:

_____
Date:
(PLEASE FILL OUT NEXT PAGE)