



Dr. Kevin R. Bellows

Chiropractic Physician

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NAME _____ HOME PHONE _____ CELL _____

ADDRESS _____ CITY _____ ZIP _____

SS# _____ BIRTHDATE _____ AGE _____ MALE _____ FEMALE _____

#OF CHILDREN _____ MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____

OCCUPATION _____ EMPLOYER _____ PHONE _____

ADDRESS _____ CITY/STATE _____

NAME OF SPOUSE _____ OCCUPATION _____

EMPLOYER ADDRESS _____ PHONE _____ SPOUSES SS# _____

HOW WERE YOU REFERRED TO THIS OFFICE? _____

PURPOSE OF THIS APPOINTMENT? _____

OTHER DOCTORS SEEN FOR THIS CONDITION? _____

IS YOUR INJURY DO TO AN ACCIDENT? _____

DO YOU HAVE HEALTH INSURANCE? _____ IF SO WHICH COMPANY? _____

ARE YOU COVERED UNDER ANY OTHER POLICY THROUGH YOURSELF OR YOUR SPOUSE? _____ IF SO WHICH COMPANY? _____ ADDRESS _____

HAVE YOU EVER SUFFERED FROM:

Dizziness _____	arthritis _____	sinus trouble _____
Backaches _____	headaches _____	anemia _____
Heart trouble _____	asthma _____	digestive disorders _____
Diabetes _____	nervousness _____	cancer _____

LIST ANY SURGICAL OPERATIONS AND YEARS _____

I UNDERSTAND AND AGREE THAT ANY INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN THE INSURANCE CARRIER AND MYSELF. FURTHERMORE, I UNERSTAND THAT DR. BELLOWS OFFICE WILL PREPARE ANY NECESSARY RECORDS AND FORMS TO ASSIST ME IN MAKING COLLECTION FROM THE INSURANCE COMPANY, AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO DR. BELLOWS WILL BE CREDITED TOWARDS MY ACCOUNT ON RECEIPT. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE MY CARE AND TREATMENT, ANY FEES FOR PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE

PATIENT SIGNATURE _____ DATE _____