

SaJune Medical Center

954 Lake Baldwin Lane Orlando, FL 32814

Ph: 407-478-9797 Fax:407-478-9798

www.sajune.com

GENERAL INFORMATION:

PATIENT LAST NAME _____ FIRST NAME _____ EMAIL: _____

ADDRESS _____ CARE OF _____ PHONE (CELL) _____
(Parent or financially responsible person)

CITY _____ STATE _____ ZIP _____ PHONE (WK) _____

DRIVER'S LIC. # _____ NO. CHILDREN _____ PHONE (HM) _____

M F Married Single Widowed Divorced DOB ____/____/____ SS# ____-____-____

PATIENT'S EMPLOYER: _____ OCCUPATION _____

EMPLOYERS ADDRESS: _____ CITY _____ ZIP _____

EMPLOYMENT: Full Time Part Time Retired Not Employed STUDENT: Full Time Part Time

OUT OF STATE ADDRESS _____ PHONE _____

SPOUSE'S NAME _____ SPOUSE'S EMPLOYER _____ NATIVE LANGUAGE _____

Referred to the Clinic by:

Health Fair/Expo Medical Doctor Internet Chiropractor Ad in Natural Awakenings Staff
 Lifestyle Magazine Walk-In Insurance Listing Patient _____ Other _____

INSURANCE INFORMATION IF APPLICABLE

COMMERCIAL INSURANCE AND MEDICARE ONLY

PRIMARY INSURANCE COMPANY NAME TYPE <input type="checkbox"/> GROUP <input type="checkbox"/> PRIVATE MEMBERSHIP/CERT. # _____ POLICY/GROUP# _____	COMPLETE ONLY IF PATIENT IS NOT THE INSURED INSURED'S INFORMATION INSURED'S NAME _____ <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED PATIENT'S RELATIONSHIP TO INSURED _____ INSURED'S DATE OF BIRTH ____/____/____ INSURED'S EMPLOYER _____
SECONDARY INSURANCE COMPANY NAME TYPE <input type="checkbox"/> GROUP <input type="checkbox"/> PRIVATE MEMBERSHIP/CERT. # _____ POLICY/GROUP# _____	INSURED'S NAME _____ <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED PATIENT'S RELATIONSHIP TO INSURED _____ INSURED'S DATE OF BIRTH ____/____/____ INSURED'S EMPLOYER _____

AUTOMOBILE ACCIDENT / WORKERS COMPENSATION ONLY

INSURANCE CO. _____ CLAIM # _____ POLICY # _____
ADDRESS _____ PHONE # _____
CITY _____ STATE _____ ZIP _____ ADJUSTER'S NAME _____
ATTORNEY'S NAME _____ CONTACT NAME _____ PHONE _____
ADDRESS _____

RELEASE AND ASSIGNMENT

I authorize release of any information necessary to process my insurance claims and assign and request payment directly to my physicians.

Patient's Signature _____ **Date** _____