

Dr. Fred E. Russo C.C.S.P.

Tallahassee Chiropractic Sports Medicine & Rehab Center

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INSURANCE INFORMATION

Patient Last Name _____ First Name _____ Middle _____

INSURANCE TYPE Check all those that apply: Auto Injury Worker's Compensation

Insurance Information

Insurance Company _____ Phone # () _____

Claims Address: _____

Insured's Name _____ Date of Birth _____

Claim # _____ / Policy # _____

Adjuster's Name _____ Phone # _____

Secondary Insurance

Insurance Company _____ Phone # () _____

Address: _____

Insured's Name _____ Date of Birth _____

Claim/ID # _____ Group # _____

Responsible Party Complete this section if you are not the patient but are responsible for the bill.

Responsible Party _____

Relationship to Patient _____ SS# _____ DOB _____

Home Address: _____ Apt # _____

City _____ State _____ Zip _____

Home Phone# _____ Work _____ Cell _____

Employer Name _____ Occupation _____

ATTORNEY INFORMATION

Do you have an attorney? Y N If yes, complete information. If no, do you intend to get one? Y N

Name _____ Phone # _____ Fax _____

Address: _____ Contact: _____