Cove Family Healthcare and Chiropractic
1007 W Bus 190 STE A - Copperas Cove, TX 76522
Phone: (254) 542-2440 • Fax: (254) 518-2237

Patient Information

Name: _____ Date of Birth _____

Address: _____ City, State, Zip: _____

Social Security #: _____ Gender: ☐ M ☐ F Driver's license# & State: _____

Phone#: _____ Cell carrier: _____ Work #: _____ Preferred Name: _____

Email: _____ Employment Status: ☐ Employed ☐ Student ☐ Other: _____

Ethnicity: ☐ Asian ☐ Black ☐ Caucasian ☐ Hispanic ☐ Other Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Information

Employer: _____ Occupation: _____

Address: _____ City, State, Zip: _____

Responsible Party Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Social Security #: _____ Responsible Party's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Insurance Information

Name of Insured: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Social Security #: _____ Phone: _____

Insurance Company: _____ Group #: _____ ID Number: _____

Address: _____ City, State, Zip: _____

Spouse Information

Name: (First, Middle, Last) _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Social Security #: _____ Employer: _____ Employer Phone: _____

Relative to Contact in Case of Emergency

Name: _____ Phone: _____ Relationship to Patient:

Address: _____ City, State, Zip: _____

Is Your Illness or Injury Related to Any of the Following?

☐ Employment ☐ Emergency ☐ Accident ☐ Auto Accident (State of Auto Accident) _____

If Employment related, has employer been notified? ☐ Yes ☐ No Employer Contact Name: _____

Employer Contact Phone and Extension: _____

How Were You Referred to Our Office?

☐ Website ☐ By a Doctor ☐ By a Patient ☐ Internet ☐ Other _____

Please print the name of your source: _____

Consent to Treatment / Financial Responsibility and Assignment of Benefits

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examination, and treatment.

I hereby assign, transfer, and set over to Cove Physical Rehab LLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I certify that I have read this form and understand its contents.

Patient or Other Legally Authorized Person: _____ Date: _____