ADVANCED BODY SOLUTIONS, Inc

Patient Demographic Information

Patient Legal Name:_____
(First) (Middle Initial) (Last)

Preferred Nickname:_____ Date of Birth:_____/_____/_____

Gender:_____ Pronoun:_____ SSN:_____ Marital Status:_____

Address:_____
(City) (State) (Zip)

Home/Cell Phone #:_____ Work Phone #:_____

Email Address:_____

How did you hear about our clinic?:_____

Emergency Contact

Name:_____ Relationship:_____ Phone #:_____

Financial Responsible Party (Guarantor)

Name:_____ Relationship:_____ Phone #:_____

Address:_____
(City) (State) (Zip)

Primary Insurance Information ☐Private Insurance ☐Auto Claim ☐Workers Comp Claim

Carrier Name:_____

ID #:_____ Group #:_____

Relationship to insured: Self Spouse Child Other

Subscriber Name:_____ Date of Birth:_____/_____/_____

*If Auto or Workers Comp claim: Date of Injury:_____/_____/_____

*Adjuster Name:_____ Phone #:_____

Secondary Insurance Information ☐Private Insurance ☐Auto Claim ☐Workers Comp Claim

Carrier Name:_____

ID #:_____ Group #:_____

Relationship to insured: Self Spouse Child Other

Subscriber Name:_____ Date of Birth:_____/_____/_____

Consent to Treatment

By signing below, I do hereby voluntarily consent to be treated with Massage / Manual Therapy by an Alaska State Licensed Massage Therapist at Advanced Body Solutions, Inc. I understand that massage is designed for the purpose of relaxation, relief from tension, muscle spasms, and poor circulation and massage therapist cannot diagnose medical issues/diseases/disorders or perform spinal manipulations.

Patient / Guardian Signature:_____Date:_____

ABS Staff: ☐ Copy of Insurance card ☐ Copy of ID
☐ Reviewed ☐ Entered ☐ Scanned ☐ Confirmed