

Dr. ANDREW J. LEWIS, D.C.

Patient Demographic & Insurance Information

First Name _____ Last Name _____ MI _____

Street _____ City _____ State ____ Zip _____

Tel# (_____) _____ DOB ____/____/____ SS# ____/____/____ Male/Female

*Policy Holder's name: _____ DOB: ____/____/____

Patient's Relationship to Insured (circle): Spouse/ Child/ Other

Primary Ins. Type: Auto – Work Comp - Slip & Fall - Cash – LOP (atty only-No Ins)

Onset Date / Auto Accident Date/ Injury Date: ____/____/____

FIRST TREATMENT DATE: ____/____/____

ICD10 DX:

A: _____ B: _____ C: _____ D: _____

E: _____ F: _____ G: _____ H: _____

I: _____ J: _____ K: _____ L: _____

****PRIMARY Ins. Co. Name:** _____ **Tel#:** _____

Address : _____, City _____ State: ____ Zip: _____

Claim# or Id# _____ Pol# or Grp# _____

***SECONDARY Ins. Co. Name:** _____ **Tel#:** _____

Address: _____, City: _____ State: ____ Zip: _____

Claim or Id# _____ Pol# or Grp # _____

Attorney's Name: _____ **Tel#** _____

Address: _____