Registration Form

Please print this page, complete the form, and bring to your appointment

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❏ Mr. ❏ Mrs.	❏ Miss ❏ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❏ Yes ❏ No	If no, what is your legal name?	Former Name:	Birth Date: / /	Age:	Sex: ❏ M ❏ F

Street Address:	Social Security Number:	Home Phone Number: ( )

P.O. Box:	City:	State:	Zip Code:

Occupation:	Employer:	Employer Phone Number: ( )

Chose clinic because…/ Referred to clinic by… (please check one box):	❏ Dr.	❏ Insurance Plan	❏ Hospital

❏ Family	❏ Friend	❏ Close to home/work	❏ Yellow Pages	❏ Other

Other family members seen here:

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

Primary Insurance:	Group # | Policy #	ID #	Phone:
Secondary Insurance:	Group # | Policy #	ID #	Phone:

Occupation:	Employer:	Employer Address:	Employer Phone Number: ( )

Is this patient covered by insurance? ❏ Yes ❏ No

Subscriber's Name:	Subscriber's S.S.No.:	Birth Date: / /	Address:	Phone:

Patient's relationship to subscriber:	❏ Self	❏ Spouse	❏ Child	❏ Other	Sex: M / F

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):	Relationship to patient:	Home Phone #: ( )	Work Phone #: ( )

A. I hereby authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignments.

B. I authorize payment of any medical benefit from third parties for benefits subitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payments to me or you based in whole, or in part, up on the charges made for your services.

C. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe you.

D. I further agree that this Authorization and Assignment is irrevocable until all monies owed to Unfried Chiropractic are paid in full.

Patient/Guardian Signature

Date