REGISTRATION FORM

PATIENT REGISTRATION

PLEASE PRINT ALL ANSWERS

Name ______________________ Age _______ Sex ❑ M / ❑ F Date _____/_____/_____

Address ______________________ City: ______________________ Zip Code: ____________

Phone (______) ______________* Work (______) ______________* Cell (______) ______________*

Best time to call _________ Which # is best ______________ E-mail ______________________

Social Security #______-_____-________ Birth Date _____/_____/_____ Family Doctor ______________________

❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed Spouses Name ______________________

Emergency Contact Person ______________________ Ph # (______) ______________ Relationship ______________________

How did you hear about us? ______________________

RESPONSIBLE PARTY

CHECK HERE IF PATIENT IS RESPONSIBLE PARTY ❑

Name: ______________________ Birth Date _____/_____/_____ Relationship to patient: ______________________

Address: ______________________ ______________________ Phone: (______) ______________*

City: ______________________ State: ________ Zip Code: _________ S. S. #:______-_____-________

Employer: ______________________ Employer Phone #: (______) ______________*

Address: ______________________

City: ______________________ State: _____ Zip Code: ______________

PRIMARY INSURANCE

Name of Insurance Company: ______________________ Effective Date: _____/_____/_________

Name of Policy Holder: ______________________ Group Number: ______________________

Policy Holder D.O.B. _____/_____/_________ Policy Number: ______________________

SECONDARY INSURANCE

Name of Insurance Company: ______________________ Effective Date: _____/_____/_________

Name of Policy Holder: ______________________ Group Number: ______________________

Policy Holder D.O.B. _____/_____/_________ Policy Number: ______________________

WORKER'S COMPENSATION INFORMATION

Was an accident report filed? ❑ Yes ❑ No Date of Injury: _____/_____/_________

Employer (at time of injury): ______________________ Employer Phone: (______) ______________*

<u>ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION:</u> I hereby assign all chiropractic, medical and/or physical therapy benefits, to include major medical benefits to which I am entitled including Medicare and other government sponsored programs, private insurance and any other health plans to Montgomery Chiropractic Center, Inc. This assignment will remain in effect until revoked by me in writing. I hereby authorize Montgomery Chiropractic Center, Inc. to release any/all information necessary to secure payment of said benefits. I understand that I am financially responsible for all charges whether or not paid by said insurance, including Worker's Compensation claims.

X ______________________________________ ________/________/________

Patient/Guardian Signature Date