



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: (____) _____ *

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION: 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