Comprehensive Chiropractic
Patient Registration

First Name:		Spouse First Name:
Middle Initial:		Spouse Middle Initial:
Last Name:		Spouse Last Name:
Street Address:		Spouse Home Phone:
City: State: Zip:		Spouse Work Phone:
Home Phone:		
Work Phone:		Patient's Employer Name:
Cell Phone:		Patient's Employer Street Address:
Birth Date: / /		City: State: Zip:
Sex: Male Female		
Email: @ .		Emergency Contract:
SSN:		Emergency Phone:
Martial Status: Single Married Divorced Widowed		
Emp Status: Full-Time Part-Time Retired Unemployed		How were you referred to our office?

INSURED INFORMATION		BILLING INFORMATION
Relationship to Insured: Self Spouse Child Other		Billing Address: Self Insured Other *(If other, please complete information below:)*
Insured First Name:		Billing First Name:
Insured Middle Initial:		Billing Middle Initial:
Insured Last Name:		Billing Last Name:
Insured Street Address:		Billing Street Address:
City: State: Zip:		City: State: Zip:
Home Phone:		Home Phone:
Work Phone:		Work Phone:
Cell Phone:		Cell Phone:
Birth Date: / /		Birth Date: / /
Sex: Male Female		Sex: Male Female
SSN:		SSN:
Insured Employer:		Billing Employer:

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I authorize the release of medical information to insurance carriers and/or their agents. I also authorize payment of medical benefits to be made directly to the provider.

Signature (Patient OR Parent/Guardian if under 18 yrs. of age.) Date

I understand that if my insurance company does not pay, I am responsible for payment. I also understand that if I default in payment, I am responsible for the payment as well as any costs (collection and/or attorney fees) incurred to collect the payment.

Signature (Patient OR Parent/Guardian if under 18 yrs. of age.) Date