~PATIENT REGISTRATION~

CHIROPRACTIC WORKS WELLNESS CENTER

__ New Pt. __ Updated Pt. Info

Patient Last Name | First | MI

Mailing Address | Apt or Unit #

City | State | Zip

( ) Home Telephone | Date of Birth

Age | Marital Status (Circle) M-S-D-W | Sex (circle) M-F | Social Security # (SSN)

E-Mail Address

( ) Cell Phone #

Spouse's Name

Occupation | ( ) Work Telephone

Employer's Name

Last Name of FAMILY PHYSICIAN | First Name

( ) Physician's Telephone

GUARANTOR NAME and SSN-Person to Bill if other than Patient

Mailing address | Apt or Unit #

City | State | Zip

How did you hear about our practice?

Yellow Pages **Friend** _____ Name **Referring Physician** _____ Name

EXTENDED AUTHORIZATION AND CONSENT

I request that payment under the medical insurance program be made directly to the above named provider on any unpaid bills for services provided on or after the date indicated below. I authorize any holder of medical or other information about me to release to the Social Security Administration, it's intermediaries or carriers of insurance companies, any information needed for this or a related Medicare or insurance claim. I understand that I am financially responsible for all charges not covered by my insurance, including those resulting from my failure to obtain necessary referral and/or other authorizations from my primary care and/or referring physician when required. I permit a copy of this authorization to be used in place of the original.

Signature of Patient or Authorized Representative: _____ **Date:** _____

Primary Insurance Information

(Please attach a copy of Ins. Card)

Patient's relationship to insured: Self Spouse Child Other

Subscriber's Name | Date of Birth

Subscriber's ID# | Co-Pay for OV

Ins. Company Name

Ins. Co. Address

City | State | Zip

Secondary Insurance Information

(Please attach a copy of Ins. Card)

Patient's relationship to insured: Self Spouse Child Other

Subscriber's Name | Date of Birth

Subscriber's ID# | Co-Pay for OV

Ins. Company Name

Ins. Co. Address

City | State | Zip