LIFE CHIROPRACTIC OF OLNEY
REGISTRATION FORM

(Please Print)

Today's Date:	Email:

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 not, what is your legal name?	Social Security No.:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:		Home Phone no.: ( )

City	State	ZIP Code	Cell Phone No.: ( )

Occupation:	Employer:	Work Phone No.: ( )

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

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your photo ID & insurance card to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Name of Primary/Auto Insurance (if applicable): Policy/Claim No: Group No.:

Subscriber's name, if different:	Subscriber's S.S. no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Policy No.:	Group No.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone No.: ( )	Cell Phone No.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Life Chiropractic of Olney or insurance company to release any information required toprocess my claims.

_____ _____

Patient/Guardian Signature *Date*