Champion Chiropractic
4532 E. Lone Mountain Rd. STE 107
Cave Creek, AZ 85331
480-595-0001

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please use full legal name, no nicknames) **Date:_____**

Last Name: _____First Name: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) - _____ - _____

Cell Phone: (_____) - _____ - _____

Date of Birth:_____ Age:_____ Sex:_____ Social Security #:_____

Employer Name and Address:_____

Email Address: _____

Emergency Contact: _____ Phone: _____

May we thank someone for referring you to our office?_____

GUARANTOR INFORMATION (List person responsible for payment – use full legal name)

Relationship to Patient: Self_____ Spouse_____ Parent_____ Other_____

Last Name: _____ First Name: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) - _____ - _____ Date of Birth: _____

Cell Phone: (_____) - _____ - _____

INSURANCE INFORMATION (We accept Medicare, but are out-of-network for all other insurance plans. If you would like us to verify if you have out-of-network Chiropractic benefits, please give the receptionist your insurance card and ID to make copies.)

Insurance Company:_____ Insured's Name:_____

Insured's Date of Birth:_____ Policy/I.D.:_____