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.:_______________________________