REGISTRATION INFORMATION

PATIENT INFORMATION

First Name:_____ MI: _____ Last Name:_____ Social Security:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Sex: ☐ M ☐ F Date of Birth: _____Age:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer and Employer's Address: _____

Home Phone: _____ Work Phone: _____

Student Status: ☐ Full Time: ☐ Part Time Name of School:

RESPONSIBLE PARTY INFORMATION

If you are the responsible party mark "self" and move down to "Insurance Information".
Patient's relationship to responsible party: ☐ Self ☐ Spouse ☐ Dependent

First Name:_____ MI: _____ Last Name:_____ Social Security:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Sex: ☐ M ☐ F Date of Birth. _____Age:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer and Employer's Address: _____

Work Phone: _____Occupation: _____

INJURY INFORMATION

Work Related? Y N Auto Related? Y N Date of injury:_____ State where injury occurred: _____

INSURANCE INFORMATION

Insurance Company:_____ Insurance Company's telephone number: _____

Claims Address: _____

Group or Policy Number: _____ Subscriber or I.D. Number: _____

Secondary Insurance Company: _____Insurance Company's telephone number:_____

Claims Address:_____

Group or Policy Number: _____Subscriber or I.D. Number:_____

Effective Date:_____ Deductible _____ Family Ded. _____ Ded. Remaining_____
Allowable Charge Covered at: _____% Chiropractic Limitations: $_____ Per Visit $_____ Per Calendar Year_____
#_____ Visits Per Year #_____ Visits Per Month

Accept Assignment? YES NO Signature On File Sufficient? ☐ YES ☐ NO
Physical Therapy Limitations?

Notes:

TURANO - McCALL GNMENT AND RELEASE

I hereby assign, transfer, and set over to CHIROPRACTIC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoking said authorization give written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature Date