PATIENT REGISTRATION

Effective Jan.1, 2013 all health care clinics are required to have the following information on file. Please complete all sections.

Last Name: _____ **First Name:** _____ **MI:** _____

Date of Birth: _____ **Gender:** Male Female Other **Weight:** _____ **Height:** _____

Marital Status: Single Married Other **Preferred Language:** English Other: _____

Do You Smoke: Current Former Never **Frequency:** (per day) 1-5 1/2 Pack 1 Pack 2+ Packs

Race: Asian African American White Other: _____

Ethnicity: Decline to Disclose Non-Hispanic Hispanic Puerto Rican Unknown

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Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Home Phone:** _____

Email Address: _____

We now offer phone, text or email reminders, please circle which method you prefer: Call Text Email

Please let us know how you found out about our Clinic: _____

Employment: Full Time Part Time Student Unemployed Retired Other: _____

Company Name: _____

Job Title: _____

Work Phone: _____ **Ext:** _____

☐ Please check this box if you *do not* want to be contacted at work.

Emergency Contact: _____

(Must be a family member or someone able to make medical decisions on your behalf in the event of a medical emergency.)

Relationship to Patient: _____

Cell Phone: _____ **Home Phone:** _____

HEALTH INSURANCE VERIFICATION FORM

TO BE FILLED OUT BY PATIENT – ALL HIGHLIGHTED AREAS

☐ Checked Benefits Online

Phone #: _____ Reference / Rep.: _____

☐ New Patient ☐ Primary

☐ Related to Motor Vehicle Crash ☐ Secondary

Name as it appears on insurance card: _____ DOB: _____ ☐ Self

Subscriber (if different from above): _____ DOB: _____

☐ Spouse ☐ Child ☐ Other:_____

Ins. Provider: _____ ID # (include any letters) _____

Group Name: _____ Group # _____

Active: Y ☐ N ☐ Effective Date: _____

☐ Calendar Year ☐ Plan Year Deductible: $ _____ Remaining: $ _____

Chiropractic

Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: _____ Co-Ins: _____%

Number of Visits/Yearly Maximum Dollar Amount: _____

Used: _____ Combined: Acupuncture / Massage / Physical Therapy

Physical Therapy

Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: _____ Co-Ins: _____%

Number of Visits/Yearly Maximum Dollar Amount: _____

Used: _____ Combined: Acupuncture / Massage / Physical Therapy

Naturopathy

Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: _____ Co-Ins: _____%

Number of Visits/Yearly Maximum Dollar Amount: _____

Used: _____ Combined: Acupuncture / Massage / Physical Therapy

Massage

Coverage: Y ☐ N ☐ In-Network ☐ Out-of-Network ☐ Deductible Waived? Y ☐ N ☐

Copay: _____ Co-Ins: _____%

Number of Visits/Yearly Maximum Dollar Amount: _____

Used: _____ Combined: Acupuncture / Massage / Physical Therapy