PATIENT REGISTRATION FORM

PATIENT

First Name: _____ MI: _____ Last Name:_____

Mailing Address: _____ City: _____ State: ____ Zip: _____

SSN: _____ Sex: M ☐ F ☐ Birthdate: _____ Age: _____

Marital Status: Single Married Widowed Divorced Legally Separated Spouses Name _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Phone: Home Work Cell Email address: _____

Whom may we thank for referring you?_____

EMPLOYMENT INFORMATION

Occupation:_____ Employer:_____ Phone #: _____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship: _____

RESPONSIBLE PARTY INFORMATION

☐ Self ☐ Parent ☐ Legal Guardian Name:_____

Primary Phone:_____ Birthdate:_____ SSN:_____

INSURANCE INFORMATION- Are you **Medicare eligible?** ☐ **Yes** ☐ **No**

Type of Insurance ☐ None ☐ Private Insurance ☐ Worker's Compensation ☐ Auto Injury Date _____

Primary Insurance Carrier:_____ Subscriber:_____

Subscriber Date of Birth:_____

Secondary Insurance Carrier:_____ Subscriber:_____

Subscriber Date of Birth:_____

-AUTO CLAIMS ONLY-

Your Vehicle Insurance Carrier:_____ Claim Number:_____

Other Vehicle Insurance Carrier:_____ Claim Number:_____

RECORDS

If you would like to be able to request your records to be transmitted via electronic transmission, such as text or email, advised records may be unencrypted. There may be some level of risk that emailed or texted information could be received and read by an unauthorized third party.

If you wish to authorize such requests, please inital_____

ASSIGNMENT & RELEASE

I acknowledge that the above information is correct and accurate to the best of my knowledge. I hereby assign payment for all medical benefits to which I am entitled from private insurance and any other health plans to: Larson Chiropractic and/or Back In Action Physical Therapy. I understand that I am financially responsible for all charges whether or not paid by insurance. I also hereby authorize Larson Chiropractic, Back In Action Physical Therapy and/or their agents to release all information necessary to process my claims and secure payment from the insurance company(ies) listed above.

_____ _____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date Relationship to Patient