Whole Health Chiropractic Center
Registration

Patient Information

Thank you for choosing our office for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We would be happy to help.

(Please Print)

Name____ Date____________ Patient #____________
First MI Last

Email Address: ______________________________

Address_________________________________City______________State_____Zip__________

Sex: Female Male Age:__________

Birthdate: ______________ Soc. Sec. #__________________

Are you: Minor Single Married Divorced Widowed Separated

Your Employer: ______________________________ Occupation:____________________________

Spouse's Name: ______________________________________Birthdate______________

Children ______________________________________

Whom may we THANK for referring you to us? ____________________________________

Have you ever received Chiropractic Care? Yes No

Phone Numbers:

Home___________________________ Pager/Cell ____________________________

Work____________________________ Ext._______

Best time & place to call you: ____

IN CASE OF EMERGENCY- CONTACT

Name________________________________ Relationship______________________

Home Phone __________________________ Work phone______________________

My Account Will Be Handled By:

Cash Insurance Work Comp. Personal Injury Medicare

Responsible Party (If Applicable):

Name of person responsible for this account ____

Relationship to Patient______________ Phone ______________ SS#______________________

Address______________________________________ City______________ State_____ Zip_____

Health Insurance Information

Insurance Company________________________________ Phone #________________________

Name of Insured_______________________________ Relation to Patient__________________

ID#____________________________ Group #____________Employer_____________________

DO YOU HAVE ADDITIONAL INSURANCE? Yes No

Insurance Company_______________________________ Phone #_________________________

Name of Insured_______________________________ Relation to Patient__________________

ID # _____________________________Group #___________ Employer_____________________

I hereby authorize and request my insurance company to pay directly to the Doctor the amounts due on my claim for the services rendered to me or my dependent. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize the Doctors of Whole Health Chiropractic and whomever they may designate as their assistants to administer treatment as they so deem necessary. I understand that there is no guarantee of results from this care.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF CHIROPRACTIC TREATMENT REGARDLESS OF INSURANCE COVERAGE

Patient Signature____

Parent/Guardian Signature____