DEMYEN FAMILY CHIROPRACTIC

REGISTRATION FORM

Patient # _____ (Please Print)

Today's date:	PCP:	Are you a U.S. Veteran? ❑ Yes ❑ No

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one): Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former/maiden name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security #:			Home phone #: ( )	
P.O. box:	City:		State:		ZIP Code:	
Occupation:	Employer:				Employer phone #: ( )	
Chose clinic because/Referred to clinic by (please check one box):		❑ Family:			❑ Friend:	
❑ Ad	❑ Internet	❑ Close to home / work	❑ Yellow Pages	❑ Other		
Email address:					Cell phone #: ( )	
Other family members seen here:						
Do you have children? Y or N	Names & ages:					

INSURANCE INFORMATION

(Please give your insurance card and driver's license to the receptionist)

Person responsible for bill:	Birth date: / /	Address (if different):			Home phone #: ( )
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:			Employer phone #: ( )
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance	❑ Humana	❑ Principle	❑ BCBS	❑ United	❑ Aetna
❑ Cigna	❑ Medicaid	❑ Medicare	❑ Welfare *(Please provide coupon)*	❑ Other	
Subscriber's name:	Subscriber's S.S. #	Birth date: / /	Group #:	Policy #:	Chiropractic Coverage? Y N
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group #:		Policy #:
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Demyen Family Chiropractic or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*