# DEMYEN FAMILY CHIROPRACTIC

## REGISTRATION FORM

Patient # _____ (Please Print)

| | |
|---|---|
| Today's date: | PCP: |

### CHILD'S INFORMATION

| | | | | |
|---|---|---|---|---|
| Child's last name: | First: | | | Middle initial: |
| Is this their legal name? ❑ Yes ❑ No | If not, what is their legal name? | Birth date: / / | Age: | Sex: ❑ M ❑ F |
| Street address: | | Social security #: | | Home phone #: ( ) |
| P.O. box: | City: | State: | ZIP code: | |
| School: | | | Grade: | |

| | | | | |
|---|---|---|---|---|
| Chose clinic because/Referred to clinic by (please check one box): | ❑ Family: | | ❑ Friend: | |
| ❑ Ad | ❑ Internet | ❑ Close to home / work | ❑ Yellow Pages | ❑ Other: |
| Parent's email address: | | | | Cell phone #: |
| Other family members seen here: | | | | ( ) |
| Do they have siblings? 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 |
| Name of secondary insurance (if applicable): | Subscriber's name: | | Group #: | Policy #: | |

### IN CASE OF EMERGENCY

| | | | |
|---|---|---|---|
| Name of local friend or relative (not living at same address): | Relationship to child: | 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.

*Parent/Guardian signature* *Date*