Plainfield Chiropractic And Rehabilitation, LTD.
Registration Form
PLEASE PRINT ALL INFORMATION CLEARLY

Patient's Legal Name: _____ DOB: _____ Age: _____

Address: _____ Home phone: _____

City/State/Zip: _____ Cell phone: _____

E-mail address: _____ SSN: _____ (required for claims)

☐ I authorize your office to contact me via e-mail and cell phone

Marital status: Single Married Divorced Widow/widower Separated

If married, spouse's name: _____ # of children: _____

Occupation: _____ Work phone: _____

Employer name: _____ Ethnicity/Race: _____

PERSON WHO CARRIES THE INSURANCE FOR THE PATIENT

☐ Same as patient

Name: _____ Date of birth: _____

☐ Address same as patient

_____ Home phone: _____

_____ Work phone: _____

Relationship to patient: _____ Cell phone: _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

☐ Same as patient

Name: _____ Home phone: _____

☐ Address same as patient Work phone: _____

_____ Cell phone: _____

_____

Relationship to patient: _____

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NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU

Name: _____ Home phone: _____

Work phone: _____ Cell phone: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Home phone: _____

Relationship to patient: _____ Work phone: _____

Cell phone: _____

Primary Care Physician: _____

How did you hear about our office? _____

Relationship to patient: _____

Have you ever received professional chiropractic treatments before? Yes No

If yes, have you been treated by another chiropractor during your current insurance benefit period? Yes No

PERMISSION AGREEMENT

___ I hereby give permission to the doctor to release any information requested by my insurance company acquired in the course of my treatment.

___ I hereby authorize and direct my insurance benefits to be paid directly to the doctor. I am financially responsible for non-covered services.

___ I hereby give permission to the doctor to administer treatment and perform such general procedures as deemed necessary in the diagnosis and/or treatment of my condition.

Signature: _____ Date: _____