Quality Chiropractic

Quality Chiropractic Registration Form

Date:_____

Personal Information

Last Name:_____ First Name:_____ Initial:_____

Address: _____

Street City State Zip Code

DOB:_____ Age_____ ☐Male ☐Female Social Security #_____-_____-_____

Home Number:_____ Work:_____ Cell:_____

E-Mail:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Number of Children:_____

Spouse's Name:_____

Employer:_____ Occupation:_____

Address: _____

Street City State Zip Code

Work Phone #:_____

Emergency Contact:_____ Phone Number_____

Insurance Information

Would you like to file your health insurance? ☐Yes ☐No Please Initial:_____

Insurance company:_____ Policy Holder_____

Policy Number or ID:_____Group Number_____

Policy Holder's SSN:_____ Policy Holder's DOB:_____

Patient Relationship to Policy Holder:_____

Is patient covered by additional Insurance? ☐Yes ☐No

Secondary Insurance:

Insurance company:_____ Policy Holder_____

Policy Number or ID:_____Group Number_____

Accident Information

Is this visit related to an accident? ☐Yes ☐No

If yes, **Auto accident** ☐ **Work related accident** ☐ **Other** ☐_____**DOA:**_____

Attorney Information: Name:_____ Phone #_____ Fax:_____

Auto accident (accident was reported to **my** Auto Insurance)

Auto Insurance Company:_____Policy #_____

Auto Insurance Claim#_____Phone Number_____

Work Injury (My employer has authorized treatment; therefore Worker's Compensation will cover treatment)

Worker's Compensation Company:_____Phone_____

Contact Name:_____ Claim #_____

If you prefer to keep type of payment on file, please complete the following:

Credit Card #:_____ Exp. Date:_____ Visa Master Card Discovery

I authorize Quality Chiropractic to charge my account each visit. **X**_____

I hereby certify that the statements and answers given in this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health and personal information. Patient signature:_____**Date**_____