

NEW PATIENT REGISTRATION FORM

Please fill out this form completely. All information is strictly confidential.

Please print legibly. Thank you.

NAME: _____ DATE: _____

STREET ADDRESS: _____

CITY, STATE, ZIP CODE: _____

HOME PHONE NUMBER: (____) _____ CELL PHONE NUMBER: (____) _____

DATE OF BIRTH: _____ YOUR SOCIAL SECURITY #: _____

SEX: M F MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW SEPARATED

ARE YOU A STUDENT: FT PT ARE YOU EMPLOYED: FT PT NOT EMPLOYED

OCCUPATION: _____ HOW LONG AT CURRENT JOB: _____

EMPLOYER: _____ WORK PHONE: (____) _____ EXT. _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: (____) _____

IS YOUR CONDITION RELATED TO:

YOUR EMPLOYMENT: NO YES IF YES, IN WHAT STATE: _____

AN AUTOMOBILE ACCIDENT: NO YES IF YES, IN WHAT STATE: _____

ANOTHER ACCIDENT: NO YES IF YES, PLEASE DESCRIBE: _____

ARE YOU COVERED BY MEDICARE: NO YES IF YES, ID#: _____

DO YOU HAVE HEALTH INSURANCE: NO YES IF YES, PLEASE COMPLETE THE NEXT SECTION:

NAME OF INSURANCE CO: _____

ID #: _____ ACCOUNT # OR GROUP #: _____

ARE YOU THE PRIMARY INSURED: YES NO IF NO, PLEASE COMPLETE THE FOLLOWING:

PRIMARY INSURED'S NAME: _____ RELATIONSHIP: SPOUSE PARENT

PRIMARY INSURED'S BIRTH DATE: _____ SOCIAL SECURITY #: _____

PRIMARY INSURED'S OCCUPATION: _____ EMPLOYER: _____

***IF YOU CARRY A SECONDARY INSURANCE POLICY, OR IF THIS INJURY IS DUE TO AN AUTOMOBILE ACCIDENT,
OR A WORKER'S COMPENSATION INJURY, PLEASE ALSO COMPLETE THE REVERSE SIDE OF THIS FORM.***

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the entire balance on my account for professional services rendered. I hereby authorize the Doctor(s) to release any medical or other information necessary to process this claim and to secure the payment of benefits. I also request payment of government or medical benefits either to myself or to the party who accepts assignment at Miano Family Chiropractic Center, LLC. I authorize the use of this signature on my insurance submissions.

SIGNATURE

PARENT / GUARDIAN (IF MINOR)

TODAY'S DATE

ADDITIONAL INSURANCE POLICY INFORMATION

PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT YOUR SECONDARY INSURANCE POLICY,
YOUR AUTOMOBILE INSURANCE POLICY, OR YOUR WORKER'S COMPENSATION INSURANCE POLICY.

NAME: _____ DATE: _____

SECONDARY INSURANCE POLICY

NAME OF SECONDARY INSURANCE CO: _____

ID #: _____ ACCOUNT # OR GROUP #: _____

ARE YOU THE PRIMARY INSURED: YES NO IF NO, PLEASE COMPLETE THE FOLLOWING:

PRIMARY INSURED'S NAME: _____ RELATIONSHIP: SPOUSE PARENT

PRIMARY INSURED'S BIRTH DATE: _____ SOCIAL SECURITY #: _____

PRIMARY INSURED'S OCCUPATION: _____ EMPLOYER: _____

AUTOMOBILE INSURANCE POLICY

STATE IN WHICH YOUR ACCIDENT OCCURRED: _____ HAS A CLAIM BEEN FILED: YES NO

NAME OF YOUR INSURANCE COMPANY: _____

INSURANCE COMPANY'S PHONE NUMBER : (____) _____ FAX NUMBER: (____) _____

CLAIM NUMBER: _____

CLAIM ADJUSTOR NAME: _____

HAVE YOU RETAINED AN ATTORNEY: NO YES IF YES, PLEASE PROVIDE THE FOLLOWING:

ATTORNEY'S NAME / PRACTICE NAME: _____

ATTORNEY'S ADDRESS: _____

ATTORNEY'S PHONE NUMBER: (____) _____ ATTORNEY'S FAX NUMBER: (____) _____

WORKER'S COMPENSATION POLICY

STATE IN WHICH YOUR ACCIDENT OCCURRED: _____ HAS A CLAIM BEEN FILED: YES NO

NAME OF YOUR INSURANCE COMPANY: _____

INSURANCE COMPANY'S PHONE NUMBER : (____) _____ FAX NUMBER: (____) _____

CLAIM NUMBER: _____

CLAIM ADJUSTOR NAME: _____

HAVE YOU RETAINED AN ATTORNEY: NO YES IF YES, PLEASE PROVIDE THE FOLLOWING:

ATTORNEY'S NAME / PRACTICE NAME: _____

ATTORNEY'S ADDRESS: _____

ATTORNEY'S PHONE NUMBER: (____) _____ ATTORNEY'S FAX NUMBER: (____) _____

SIGNATURE

PARENT / GUARDIAN (IF MINOR)

TODAY'S DATE