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