RN: ________________

PATIENT REGISTRATION

Date:____

Patient: ____ Date of Birth _______________ ☐ Male ☐ Female

Address: ____ Social Security #: _______________________________________

City, State, Zip: _____________________________________ Marital Status: ☐ S ☐ M ☐ D ☐ W # of Children ________

Home Phone:______________________________________ Spouse's Name: ____

Employer: ____ Spouse's Employer: _____________________________________

Employer's Address: __________________________________ Spouse's Occupation: ____________________________________

Occupation: ____ Spouse's Work Phone #: _________________________________

Work phone: __________________________ Ext. __________

Cell phone: ____ E-mail address: _______________________________________

Part-time resident? ☐ Yes ☐ No Other address: ____

City, State, Zip: ____ Phone: _______________________

In case of emergency, notify __________________________ Relationship ______________Phone # ___________________________

Name and address of responsible party (if other than you): ____

PLEASE SUPPLLY INFORMATION FOR BOTH INSURANCE CARRIERS (IF APPLICABLE)

	PRIMARY INSURANCE	SECONDARY INSURANCE
Patient's relationship to insured	☐ Self ☐ Child ☐ Spouse ☐ Other	☐ Self ☐ Child ☐ Spouse ☐ Other
Insurance Carrier Name:		
Insured's Name:		
Insured's Date of Birth		
Insured's ID#:		

PAYMENT, BENEFITS & MEDICAL RELEASE AUTHORIZATION

I consent to examination / treatment at this office. I authorize this office to release any information deemed appropriate concerning my care to any insurance company, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered, and I hereby release the office of any consequences thereof. I agree that a photocopy of this agreement shall serve as the original. I assign and direct payment of medical benefits to David M. Israel, D.C. for services rendered. I fully understand and agree that insurance policies are an arrangement between an insurance carrier and myself, and that I am responsible for payment of any expenses not paid by insurance.

____ ______________________________________

Patient / Guardian signature Date