Unfried Chiropractic
REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:			Home phone no.: ( )
P.O. box:	City:		State:		ZIP Code:
Occupation:	Employer:				Employer phone no.: ( )
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance:	Group#/Policy#	ID#	Phone:
Secondary Insurance:	Group#/Policy#	ID#	Phone:

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Address:	Phone:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	Sex: M/F

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

A. I hereby authorize release of any medical information necessary to process this claim and request paymenl of insurance benefits either to myself or to the party who accepts assignments.

B. I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney out ofproceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in. part, up on the charges made for your services.

C. In the event any insurance company obligaled by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, ;rhereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is beiieved \0 be correctly set forth underperiinent data) and authorize you 10 prosecute said aclion eiiner in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe you.

D. I further agree that this Authorization and Assignment is irrevocable until all monies owed Unfried Chiropractic are paid in full.

Patient/Guardian signature *Date*