



## REGISTRATION INFORMATION (Please fill out in BLACK ink only)

Client Name \_\_\_\_\_ DOB \_\_\_\_\_  
(Last) (First) (M.I.)

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Phone \_\_\_\_\_ E-Mail \_\_\_\_\_ SS# \_\_\_\_\_

Client Is:  Male  Female  Single  Married  Divorced  Student  Other

Briefly describe symptoms, illness or accident \_\_\_\_\_

\_\_\_\_\_ Date of onset of symptoms \_\_\_\_\_

Employer (Company Name / School Name) \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Occupation \_\_\_\_\_ Driver's License # \_\_\_\_\_

Name of doctor or person who referred you \_\_\_\_\_

## INSURANCE INFORMATION

Policy Holder's Name \_\_\_\_\_ DOB \_\_\_\_\_

Phone \_\_\_\_\_ E-Mail \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Insurance Co. \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Ins. Phone \_\_\_\_\_ Effective Date \_\_\_\_\_

Relationship to Client:  Self  Spouse  Parent  Other

**I understand that Insurance coverage is not a guarantee of benefits and that determination will be made at the time the claim is received. I also understand that I am responsible for the balance if the claim is denied and also for any co-insurance or annual deductible that is applicable. All payments are due at the time of service. I also understand that I am responsible for all appointments and I will be charged a fee of \$65 unless I give 24 hours' notice of cancellations. Late fees are due at the next appointment.**

Signature \_\_\_\_\_ Date \_\_\_\_\_



Client Name \_\_\_\_\_

## EMERGENCY INFORMATION – Who to contact in case of emergency

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_  
(Home) (Work or Cell)

## Assignment and Release

I authorize payment of Medical Benefits to this facility/provider. I authorize release of any medical information necessary to process the claim and/or I also request payment of government benefits either to myself or party who accepts assignment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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Below to be completed by provider.

Diagnosis Date	Dx	Dx	Dx	Dx