



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 _____

Below to be completed by provider.

Diagnosis Date	Dx	Dx	Dx	Dx