

PATIENT REGISTRATION

Morgante Family Chiropractic

Today's Date _____

Last Name _____ First Name _____ Initial _____

Street _____ City _____ State _____ Zip _____

Home Phone# _____ Work Phone# _____

SS# _____ Date of Birth _____ Sex _____ Marital Status _____

Email Address _____ Employer _____

Street _____ City _____ State _____ Zip _____

Who referred you to our office? _____

INSURANCE INFORMATION

To ensure all billing is submitted properly, please provide us with the following information. The front office will also need to make a copy of your insurance card for our records.

Insurance Company _____ Phone# _____

Name of Insured _____ SS# _____ Date of Birth _____

Policy# _____ Group# _____ Contract# _____

Employer of Insured _____ Relation(patient/insured) _____

Is your condition related to Employment? NO YES Is your condition related to an Auto Accident? NO YES

Other accident? NO YES If yes, Please describe _____

When did your present symptoms appear? _____

What type of symptoms are you experiencing? _____

Have you ever had any complaints in the involved area before? No Yes If yes, please explain

- I understand that the policy set forth by Morgante Family Chiropractic requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If my account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for legal fees, collection agency fees, and any other expenses incurred in collecting on my account.*
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization and or other 3rd party, to release any information required to process insurance claims.*
- I hereby assign all benefits paid by my insurance company to Morgante Family Chiropractic..*

Signature _____ Date _____