MIDDLEBURY CHIROPRACTIC & WELLNESS CENTER
PATIENT REGISTRATION DATA

NAME: ______________________________

ADDRESS: ______________________________

CITY: ______________ STATE: ______________ ZIP: ______________

PHONE #'S: (H) ______________ (W) ______________ (Cell) ______________

EMAIL ADDRESS______________________________

SOCIAL SECURITY #: ______________ DATE OF BIRTH: ______________

EMPLOYER: ______________ POSITION: ______________

NAME, RELATION, & PHONE # OF PERSON TO NOTIFY IN CASE OF EMERGENCY:
____

PLEASE PROVIDE RECEPTIONIST WITH INSURANCE CARD(S)

PRIMARY INSURANCE: ______________________________

SECONDARY INSURANCE: ______________________________

REFERRING PRIMARY CARE PHYSICIAN:______________________________

IF INSURED PARTY IS SPOUSE OR PARENT, PLEASE INCLUDE:

NAME OF INSURED: ______________ EMPLOYER: ______________

DATE OF BIRTH: ______________SOCIAL SECURITY #: ______________

ADDRESS & PHONE # OF INSURED, IF DIFFERENT FROM PATIENT:

____

WORKER'S COMP: ________ AUTO ACCIDENT: ________ DATE OF INJURY/ACCIDENT: ________

ATTORNEY'S NAME, ADDRESS, & PHONE #:

____

I, the undersigned, have insurance benefits with ______________________________
And assign directly to Middlebury Chiropractic & Wellness Center, all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not payable by insurance. I hereby authorize any holder of medical information about me to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature Patient (or Legal Guardian): ______________________ Date: ______________