SHOEMAKER CHIROPRACTIC REGISTRATION FORM

(Please Print)

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: 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 #:	Home/Cell phone no.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer: Email:	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.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

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

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance	☐				
☐	☐	☐			

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Subscriber's Birthday Subscriber's S.S. #

IN CASE OF EMERGENCY

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

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. In the event of non-payment I agree to bear all cost of collections, court cost and legal fees, should this be required. I further agree to be financially responsible for all procedure ordered by said doctor if my insurance plans determines that they are considered non-covered. I also authorize Pain Therapy Associates Limited or insurance company to release any information required to process my claims. By signing this, I also indicate my awareness of the HIPPA rules and rights to my privacy. My privacy notice is available to me for my immediate perusal. I also acknowledge that the physicians of Pain Therapy Associates Limited are specialists in the treatment of pain-related conditions and are NOT primary care physicians.

CREDIT CARD # / / / / - / / / / - / / / / - / / / / EXP DATE - / / - / /

Patient/Guardian signature *Date*