HEINEN
CHIROPRACTIC, S.C.

Patient Registration Form

Legal First Name: _____ M.I.: _____ Last Name: _____

Date of Birth: _____ Marital Status: M S W D Social Security: _____

Spouse: _____ Spouse's Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Would you like to receive our newsletter: Y N

Employer: _____

Reason for Visit: □ Wellness □ Auto Accident □ Work Injury □ Other Injury □ Other _____

How were you referred to our office? _____

Contact person in case of emergency: _____ Phone: _____

Name of parent of minor patient: _____

Primary Health Insurance: _____

Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____ Employer: _____

Address (if different than patient): _____

Secondary Health Insurance: _____

Insured's Name: _____ Relationship to Patient: _____

Date of Birth: _____ SSN: _____ Employer: _____

Address (if different than patient): _____

This office makes payment arrangements on an individual basis. Payment arrangements will be discussed during your report of findings. If you have insurance, we will gladly accept assignment, provided we have prior certification from your insurance company. We accept assignment as a courtesy to you. Deductibles and/or coinsurance assigned by your insurance company will be your responsibility.

I hereby authorize my insurance benefits to be paid directly to Heinen Chiropractic, S.C. and acknowledge I am financially responsible for any unpaid balance. I also authorize Heinen Chiropractic, S.C. to release any information requested by my insurance company.

My signature below verifies that I have read and fully understand the above information. I understand and accept that I am responsible for all charges incurred from services rendered at Heinen Chiropractic, S.C.

Patient/Guardian Signature: _____ Date: _____