TOTALChiropractic HEALTH CENTER

Patient Registration Form

419 Daniel Webster Highway – Merrimack, NH 03054-3714
Office: (603) 423-1022 Fax: (603) 423-1023

Please complete the following information, write N/A if not applicable.

Complete this side of the form even if this is an Auto Accident or Worker's Compensation Claim.

Patient Information

First_____ MI_____ Last_____ □Male □Female

Address_____ City_____ State_____ Zip_____

Social Security #_____ Date of Birth_____/_____/_____ Drivers License #_____

Marital Status: □Single □Married □Divorced □Separated □Widowed Spouse's Name_____

Phone: Home (____) _____ Cell (____) _____ Email_____

Work (____) _____ Occupation_____ Employer_____

Employer Address_____ City_____ State_____ Zip_____

Check any and all insurance coverage you have and/or the method of payment applicable, and complete all pertinent information.

□ Cash □ Medicare □ Health Insurance □ Workers Compensation □ Auto Accident □ Other

If you are a full-time student, please fill out parent's information under Primary Guarantor!

Primary Guarantor

Please provide us with your most current insurance card to verify the information.

First_____ MI_____ Last_____ □Male □Female

Address_____ City_____ State_____ Zip_____

Social Security #_____ Date of Birth____/____/____ Phone: Home (____) _____

Employer_____ Address_____ City_____ State_____ Zip_____

Primary Insurance

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other

Insurance Company_____ Address_____ City_____ State____ Zip_____

Group Name_____ Group/Plan #_____ Insured's ID #_____

Secondary Guarantor

Please provide us with your most current insurance card to verify the information.

First_____ MI_____ Last_____ □Male □Female

Address_____ City_____ State_____ Zip_____

Social Security #_____ Date of Birth____/____/____ Phone: Home (____) _____

Employer_____ Address_____ City_____ State_____ Zip_____

Secondary Insurance

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other

Insurance Company_____ Address_____ City_____ State____ Zip_____

Group Name_____ Group/Plan #_____ Insured's ID #_____

ASSIGNMENT, AUTHORIZATION AND POLICY STATEMENT

I believe that the information is complete to the best of my knowledge. ***I will be responsible for any expenses the insurance carrier does not meet***. I fully understand and agree that the insurance polices are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are my responsibility. I hereby assign the benefits I am eligible to receive for the care rendered in this office. I authorize the office to release health information, to any insurance company, adjustor or attorney that will assist in the payment of claims. A photocopy of this form will be considered as effective and valid as the original.

Date_____ Patient_____ Resp Party_____ CA_____