Quality Chiropractic Registration Form

Date______________________

Personal Information

First Name:________________________________ Mid. Int. _____ Last Name:________________________________
Address: ____
Street City State Zip Code
Home Number:______________________ Work:_____________________ Cell:____________________
E-Mail:___________________________________
DOB:_________________ Age_______ ☐Male ☐Female Social Security #_________-_______-________
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated Number of Children:________
Spouse's Name:_________________________________

Emergency Contact:__________________________________ Phone Number_____________________________

Employer: _______________________________________ Occupation: ___________________________________
Address: ____
Street City State Zip Code
Work Phone #: ___________________________________

Health Insurance Information

Would you like to file your health insurance? ☐Yes ☐No **Please Initial:**____________________
Insurance company:_____________________________________
Policy Holder_________________________________ Policy Holder's SSN:_____________________________________
Patient Relationship to Policy Holder:______________________________ Policy Holder's DOB:____________________
Policy Number or ID:_____________________________________Group Number__________________________________

Is patient covered by additional Insurance? ☐Yes ☐No
Secondary Insurance:
Insurance company:_____________________________________ Policy Holder_______________________________
Policy Number or ID:_____________________________________Group Number__________________________________

Accident Information

Is this visit related to an accident? ☐Yes ☐No
If yes, Auto accident ☐ Work related accident ☐ Other ☐__________________________DOA:____________________
Attorney Information: Name:_______________________________ Phone #___________________ Fax:_______________
Auto accident (accident was reported to my Auto Insurance)
Auto Insurance Company:____Policy #______________________________
Auto Insurance Claim#____Phone Number_________________________
Work Injury (My employer has authorized treatment; therefore Worker's Compensation will cover treatment)
Worker's Compensation Company:_______________________________________Phone__________________________
Contact Name:____ Claim #_________________________________
If you prefer to keep type of payment on file, please complete the following:
Credit Card #:______________________________ Exp. Date:___________ Visa Master Card Discovery
I authorize Quality Chiropractic to charge my account each visit. __**X**____

I hereby certify that the statements and answers given in this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health and personal information. Patient

Signature:____ **Date**____________-____________-________