Aldrich Chiropractic Center, LLC

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birth date:	Age:	Sex: ☐ M ☐ F	Social Security no.:	Home Phone no.: ( )	Cell/Mobile Phone no.: ( )

Street address:	City:	State:	Zip Code:

Occupation:	Employer:	Employer phone no.: ( )

Employer Street address:	City:	State:	Zip Code:

Please Check work status: ☐ Full-Time ☐ Part-Time ☐ Full-Time Student ☐ Part-Time Student ☐ Not Employed

E-mail Address: Your email is used only for our office and is not distributed

Whom may we thank for referring you to us?	Name of Referral:	☐ Family/Friend	☐ Attorney	☐ Doctor

☐ Insurance Provider Book	☐ Big Yellow Pages (Columbus)	☐ Small Yellow Pages (Gahanna)	☐ Other____

Name of Family Physician:	Address:	Phone no.: ( )	*May we send him/her a letter regarding your care?* ☐ Yes ☐ No

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of Insured:	Birth date of Insured:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Name of Insurance:	Subscriber's S.S. no.:	Group no.: Plan No.:	Policy/Identification no.:	Co-payment: $

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

Name of secondary insurance	Subscriber's name:	Group no.:	Policy no.:

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

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone # ( )	Work phone # ( )

Patients or Authorized Person's Signature: The above information is true to the best of my knowledge. I authorize the release of any medical or other information necessary to process my insurance claim. This is to serve as a long-term authorization card. I authorize payment of medical benefits to Aldrich Chiropractic Center for services described on the insurance form. This authorization is to apply to all occasions of service until it is revoked in writing. I agree to pay for services not covered by insurance and understand that I am ultimately responsible for payment in full at this office.

____ ***_____Patient/Guardian signature***		______________________________ ***__Date***