Aldrich Chiropractic Center, LLC
REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle:	○ Mr. ○ Mrs. ○ Miss ○ Ms. ○ Dr.	Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed
Birth date: Age: Sex: M F	Social Security #	Cell phone:
Street Address:	City/State:	Zip Code:
Occupation:	Employer:	Employer Phone:
Employer Street Address:	City/State:	Zip Code:
Please Check Work Status: ○ Full-Time ○ Part-Time	○ Full-Time Student ○ Part-Time Student ○ Not Employed	
Email Address:		
Name of person who referred you to us?	○ Family Friend ○ Attorney ○ Doctor	○ Insurance ○ Google ○ Facebook
Name of Primary Care Physician:	Address:	Phone Number:
	INSURANCE INFORMATION	
Name of Insured: birth date of insured:	Address (if different):	Is this person a patient here ○ Yes No
Name of Insurance Company:	Member ID:_____ Group #:_____	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:	Phone Number:

Patients or Authorized Person's Signature: The above information is true to the best of my knowledge. I authorize the release of any medical of 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