Registration Form

CHIROPRACTIC PHYSICIANS GROUP

Patient Information

Date _____ (*PLEASE PRINT*) Home Phone (___) _____

Name _____ SS/HIC/Patient ID # _____

Last Name First Name Middle Initial

Address _____ Cell Phone (___)

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ____ years

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (___)_____

Whom may we thank for referring you? _____

In case of emergency who should be notified _____ Phone (___)_____

Primary Insurance

Person Responsible for Account_____

Last Name First Name Middle Initial

Relation to Patient _____ Birthdate_____ Soc. Sec # _____

Address (if different from patient's) _____ Phone (___)_____

City_____ State_____ Zip _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone (___)_____

Insurance Company _____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan_____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to patient _____ Birthdate _____

Address (if different from patient's) _____ Phone (___) _____

City _____ State_____ Zip_____

Contract # _____ Group # _____ Subscriber # _____

Names of other dependents covered under this plan _____

Assignment and release

I certify that I, and/or my dependent(s), have insurance coverage with _____

Name of Insurance Company(ies)

assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named insurance Company(ies) And their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable le for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

293 Passaic Street, Passaic NJ 07055
Tel: 973-473-3600 Fax: 973-473-3661
www.njbackdoc.com