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NEW PATIENT REGISTRATION FORM

Date_____

Section I

Legal Name: _____

Address: _____ City:_____ State: _____ Zip _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Date of Birth: _____ Age_____ Social Security #: _____ ***(for insurance purposes only)***

Check Appropriate Box: ☐ Single ☐ Married ☐ Other

Phone _____ Work Phone _____ Cell Phone _____

I prefer to be contacted via: ☐ Home phone ☐ Work phone ☐ Cell phone Cell Phone Carrier _____
Would you like to receive appointment reminder calls via text message? ☐ Yes ☐ No If yes, please initial here _____
Email Address: _____

Person to contact in case of emergency: _____ Phone _____

Whom may we thank for referring you? _____

I authorize Muskego Health and Wellness Center to use the following method(s) to disclose any appointment and/or health information: ☐ Family member (spouse, child, other) ☐ Home phone ☐ Cell phone ☐ I prefer no messages be left
Please initial here _____

Section II **Employment Information**

Employer: _____ Occupation: _____
Address: _____
City: _____ State: _____ Zip:_____ Phone: _____

Were you injured at work? ☐ Yes ☐ No Were you injured in an accident? ☐ Yes ☐ No

Section III **Insurance Information**

*******NOTE: INFORMATION REQUIRED ONLY IF INSURANCE CARD(S) NOT AVAILABLE*******

Name of Insured: _____ DOB: _____ Relationship to Patient:_____
Insurance Company:_____ Group #: _____ ID#: _____
Ins. Co. Address: _____ Ins. Co. Phone: _____
DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured: _____ DOB: _____ Relationship to Patient:_____
Insurance Company:_____ Group #: _____ ID#: _____
Ins. Co. Address: _____ Ins. Co. Phone: _____

Release of Medical Information:
I hereby authorize the release of any medical information necessary to process any insurance claim.

_____

Treatment of a Minor:
I, as legal guardian of the patient, authorize appropriate chiropractic treatment.

_____