Lederman Chiropractic & Sports Medicine Registration Form

Today's date:_____

PATIENT INFORMATION

First Name:_____ Middle Name_____ Last name:_____
Marital status (circle one) : Single / Married / Divorced / Separated / Widowed
Birth date:_____ Age:_____ Sex: _____ Race:_____

Home address information:

Street address :_____ Suite/Apt #_____
City:_____ State:_____ ZIP Code:_____

Contact info:

Home phone number:_____ Cellular phone number:_____
E-mail address:_____

Employer information:

Occupation: _____ Employer: _____
Employer Address:_____
Work phone number:_____

Chose clinic because/Referred to clinic by (please circle one);

Referral / Google Search / Close to home/work / Insurance network / other
If referred, by whom? _____
If other, please specify: _____

Insurance information:

Insurance provider name: _____ Member ID number: _____
Group number: _____

IN CASE OF EMERGENCY

Name of local friend or relative: _____ Relationship to patient: _____
Best contact phone number: _____ E-mail address: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Lederman Chiropractic & Sports Medicine or insurance company to release any information required to process my claims.

Name of Patient or Name of Guardian:_____

Patient or Guardian signature: _____
Date: _____