PATIENT REGISTRATION / INSURANCE INFORMATION

NAME____ DATE ________________________

SOCIAL SECURITY NUMBER ____

BIRTHDATE_________________________ AGE__________ GENDER M_____ F_____

HOME PHONE _________________________________ CELL______________________________

ADDRESS ____

EMAIL ADDRESS ____

WORK PHONE __________________________ EMPLOYER __________________________________

MARITAL STATUS (circle one) S M D W CU

SPOUSE/PARTNER'S NAME ____________________________ NUMBER OF CHILDREN___________

PRIMARY CARE PHYSICIAN____________________________ PHONE _________________________

EMERGENCY CONTACT ________________________________ PHONE _________________________

WHOM CAN WE THANK FOR SENDING YOU?____

Name of Insurance____________________________________ **Type of Insurance** (circle one)

PRIVATE/HMO/PPO **PERSONAL INJURY** **WORKER'S COMP** **AUTO** **NONE**

Policy Holder: **Name**_____________________________ **Relationship to Patient** ______________________

Address ____

Social Security Number _______________________________ **D.O.B.** ________________

Name of Employer:____

*I authorize payment of benefits to Cedar Wood Chiropractic for services rendered.
Signed (Insured or Authorized Person) ____________________________________ Date ___________
*I authorize the release of any information necessary to process claims. I also request payment of benefits to myself or Cedar Wood Chiropractic.
Signed (Insured or Authorized Person) ____________________________________ Date ____________