Welcome to Our Office!

NORTHERN OHIO CHIROPRACTIC

New Patient Registration Form

Name: Today's Date: MR#

Address: City/State/Zip:

Home phone: Work Phone: Cell phone:

Birthdate: Country: City: State:

Drivers License #: Social Security Number:

Education Level: □Grade School □ High School □Undergraduate □Graduate □Postgraduate

Marital Status: M W D S

Your Employer: Occupation:

Employers Address: Phone Number:

Briefly describe your current or most recent employment responsibilities:

Do you work with biohazard or hazardous waste materials?

Spouse's Name: Spouse's Employer:

Children's Name and Ages:

Person to Contact in Emergency: Phone Number:

Who may we thank for referring you?

Who is financially responsible for charges incurred from your visits? Name:

Relationship to Patient: Birthdate: Social Security #:

Employer: Address: Occupation:

Method of payment: □Cash □Check □ Credit Card □ Insurance

PLEASE LIST INSURANCE COVERAGE APPLICABLE IN THIS CASE:

Primary Ins.: Name of Insured:

ID#: Group: Provider Phone Number:

Secondary Ins.: Name of Insured:

ID#: Group: Provider Phone Number:

WC: Date of Injury: Claim # Contact: Phone #

Auto: Date of Injury: Claim # Contact: Phone #

ASSIGNMENT and RELEASE.

I, the undersigned, have insurance with and assign directly to Dr. Thomas Przybysz, D.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured Guardian **Date**