The ChiropracticHealth
& WELLNESS CENTER OF DAYTON, INC.

REGISTRATION FORM

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Maiden Name

Address	City/State	Zip

DOB	Age	Relation to Responsible Party	SS#	Home Phone	Work Phone

Sex: ☐ M ☐ F	Employer Name & Address	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	Cell Phone / E-Mail Address

Primary Care Physician	Marital Status: ☐ M ☐ S ☐ D ☐ W	Patient Student Status ☐ Part Time ☐ Full Time ☐ Not a Student

Name of siblings or other family members also coming to this practice:

How did you hear about us? ☐ Hospital Help Line ☐ Yellow Pages ☐ Provider Directory ☐ Family ☐ Friend ☐ Neighbor

Other: Name: _____ May we thank them? ☐ Yes ☐ No

☐ SAME AS PATIENT — RESPONSIBLE PARTY INFORMATION (If Different from Patient)

Person who accompanies child to visit

Last Name	First Name	Middle Initial	Maiden Name	Birthdate

Address	S.S.#	Home Phone	Cell Phone	Work Phone

City, State, Zip	Relationship to Patient	Employer Name & Address

Spouse	Spouse Employer & Address	Spouse Work Phone

EMERGENCY CONTACT *(nearest relative not living with you)*

Emergency Contact Name	Home Phone	Work Phone

Address, City, State & Zip	Other Phone	Relation to Patient

PRIMARY INSURANCE INFORMATION

Insurance Company	Group#/Plan ID	Member Number	Copay Amount	Effective Date

Subscriber Employer Name & Address	Patient Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other	Sex: ☐ M ☐ F

Subscriber Name & Address	Does your insurance require a referral to a specialist? ☐ Yes ☐ No	Subscriber DOB

SECONDARY INSURANCE INFORMATION

Insurance Company	Group#/Plan ID	Member Number	Copay Amount	Effective Date

Subscriber Employer Name & Address	Patient Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other	Sex: ☐ M ☐ F

Subscriber Name & Address	Does your insurance require a referral to a specialist? ☐ Yes ☐ No	Subscriber DOB

The undersigned patient or guardian certifies that the above facts are correct and agrees as follows:

1. Authority is granted to CHWCD to render needed treatment and/or tests to the above named patient.
2. I authorize CHWCD to release any information required for payment of claims.
3. I authorize my insurance or Medicare benefits to be paid directly to the treating physician, realizing I am responsible to pay noncovered and unauthorized service.
4. I understand that **I am responsible** for charges incurred through CHWCD, not covered by my insurance. Payment is expected at the time of my visit. If this cannot be done, I agree to make other arrangements with the office. I also agree to pay any collection or attorney's fees incurred above and beyond the past due amount.
5. I have been given CHWCD's handout on missed appointments and understand my responsibilities regarding being late or absent.

_____ _____

The above information is correct/patient or Guardian Signature — Date