Stitt Chiropractic
Patient Registration

PATIENT INFORMATION HEIGHT:_____ WEIGHT:_____ Date _____ Chart # _____

Patient _____ Sex ☐ M ☐ F Date of Birth ____/____/____
Last Name First Name Initial

Address _____ City _____ State ____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email address _____

Are you ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed SS# _____

Employer _____ Work Phone.( ) _____

Spouse / Partner's Name _____ DOB ____/____/____ SS# _____

Address _____ City _____ State ____ Zip _____

Home Phone ( ) _____ Cell Phone ( ) _____ Email address _____

Employer _____ Work Phone ( ) _____

Responsible for Payment: ☐ Self ☐ Spouse ☐ Other Other's Name _____

Emergency Contact _____ Phone ( ) _____ Relationship _____

Whom may we thank for referring you? _____ Relationship _____

INSURANCE INFORMATION

Name of Insured _____ DOB ____/____/____ Relationship _____

Primary _____ Claims Address _____

Policy # _____ Group # _____

Secondary _____ Claims Address _____

Policy # _____ Group # _____

Medicare _____ Card # _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.

I hereby authorize and request my insurance company, third-party payers and/or my attorney to pay directly to Stitt Chiropractic the amounts due on my claim for the services rendered to me. I hereby authorize the release of all information necessary, including x-rays, to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I am financially responsible for all co-payments and any charges not paid by my insurance.

I authorize the doctors of Stitt Chiropractic to administer treatment as they deem necessary. I understand there is no guarantee of results from this care.

Patient Signature _____ Date _____