# *Belnap Chiropractic Registration*

Date:______________________________ **CHART#** (office use)______________________

Name:______________________________ Sex _____Female_____Male

Address:______________________________ Birth Date:_____/_____/_______ Age:___________

(City/State)______________________________ Home phone:_______________Cell_______________

(Zip)______________________________ _____Student_____Married_____Single_____Divorced

**Employer:**______________________________ Address:______________________________

Business Phone:______________________________ (City/State Zip)______________________________

**Parent/Spouse:**______________________________ Birth Date:______/______/______

Employer:______________________________ Address:______________________________

Business Phone:______________________________ (City/State/Zip)______________________________

**Name of Emergency contact:**______________________________Phone#:__________________

Relationship?________________How did you hear about us?______________________________

**Primary Insurance Co.**______________________________**ID#**______________________

Insured: (Check One)_____Self_____Spouse_____Parent_____Other **Group#**______________________

Name of Subscriber______________________________________________Birth Date:_____/_____/_____

SS#(If no ID#)________________________ (Please allow us to copy your card)

**Secondary Insurance Co.**______________________________**ID#**______________________

Insured: (Check One)_____Self_____Spouse_____Parent_____Other **Group#**______________________

Name of Subscriber______________________________________________Birth Date:_____/_____ /_____

SS#(If no ID#)________________________ (Please allow us to copy your card)

Is condition due to an accident? __ yes __ no Accident Date:________ Work___Auto___Home___Other

Have you seen another Doctor for this accident?____yes___no **(Please notify front desk of accident.)**

Name of Attorney: (If applicable)______________________________________________________________

- **I understand that insurance is an arrangement between the insurance carrier and myself. It is my responsibility to provide insurance information <u>before</u> services are rendered in order to avoid additional fees. <u>I understand that I am financially responsible for all charges whether or not paid by insurance, as well as interest and/or service fees.</u>**
- **I hereby authorize the doctor or Belnap Chiropractic to release all information necessary to obtain payment of benefits, and I authorize use of this signature on all insurance submissions.**
- **I acknowledge that I have had an opportunity to view and/or receive a copy of the Providers Notice of Privacy Practice, and Financial Policy.**
- ***<u>I understand that there is a 24-hour cancellation policy, and if I fail to notify Belnap Chiropractic, I may be charged a $20 missed appointment fee.</u>***

**Patient's Signature**______________________________________ **Date:**______________

**(Must be 18 or older)**

**Responsible Party:**______________________________________ **Date:**______________