8.2-MTBC-F-10

A Unique Healthcare IT Company®

CONFIDENTIAL

LOGATTO CHIROPRACTIC CENTER

REGISTRATION INFORMATION

PLEASE PRINT

◯ New Patient

◯ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

DATE ____/____/_____ **EMAIL ADDRESS** _____ **HOME PHONE:** (_____) _____-_____

CELL PHONE: (_____) _____-_____

PATIENT'S NAME: _____ , _____ _____

LAST *FIRST* *MI*

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **RACE** _____

SSN: _____ - _____ - _____ **GENDER:** ◯ *M* ◯ *F* **BIRTH-DATE:** _____/_____/_____ **Ethnicity** _____

◯ *SINGLE* ◯ *MARRIED* ◯ *DIVORCED* ◯ *SEPARATED* ◯ *WIDOWED*

Preferred Language_____

Patient Employed By :_____

Business Address:_____

Occupation:_____ **Business Phone:** (_____) _____-_____

Name of Spouse/Responsible Party (If Patient is minor): _____ , _____ _____

LAST *FIRST* *MI*

Spouse/Responsible Party Employed by:_____

Business Address:_____

Occupation:_____ **Business Phone:** (_____) _____-_____

RESPONSIBLE PARTY/SPOUSE SSN : _____ - _____ - _____

DO YOU HAVE MEDICAL INSURANCE ? ◯ NO ◯ YES **If Yes:**

NAME OF PRI. INS. : _____ **ID #:** _____ **GRP #:**_____

***SUBSCRIBER'S NAME:** _____ ***BIRTH DATE:** _____/_____/_____

ADDRESS OF PRI. INS. :_____

NAME OF SEC. INS. :_____ **ID #:** _____ ***GRP #:*** _____

***SUBSCRIBER'S NAME:** _____ ***BIRTH DATE:** _____/_____/_____

ADDRESS OF SEC. INS. :_____

***Required by HIPAA**

◯ Pay my balance at the time of service ◯ Pay my balance upon receipt of first statement ◯ Make payment arrangement prior to rendering of services.

In case of emergency, who should be notified? _____ Relationship _____

Person authorized to receive PHI _____ Relationship _____

PHONE: (_____) _____-_____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____hereby authorize_____

(NAME OF INSURED) **(NAME OF INSURANCE COMPANY)**

to pay and hereby assign directly to _____all benefits, if any, otherwise payable to

(PROVIDER'S NAME)

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____

(PROVIDER'S NAME)

will be credited to my account, in accordance with the above said assignment.

_____ _____

(AUTHORIZED SIGNATURE OF SUBSCRIBER) **(DATE)**