

**CLIENT REGISTRATION
PLEASE PRINT**

Name: _____ Today's Date: _____

Address: _____ Home Phone: _____

Work Phone: _____

(City) (State) (Zip)

Cell Phone: _____

Email Address: _____

Preferred method of communication: Email Home Phone Cell Phone

Client's Relationship to person responsible for the bill: Self Spouse Child Dependent

Marital Status: Single Married Widowed Separated Divorced

Birth date: _____ Age: _____ Gender: Male Female

Referred to this Office by: _____

Client's Employer: _____

Spouse's Employer: _____

Address: _____

Address: _____

City, State Zip: _____

City, State Zip: _____

Occupation: _____

Occupation: _____

PERSON RESPONSIBLE FOR BILL, IF NOT CLIENT

Employer: _____

Address: _____

City, State Zip: _____

INSURANCE AND/OR INJURY INFORMATION

Insurance: _____

Other Insurance: _____

Subscriber's Name: _____

Subscriber's Name: _____

Group #: _____

Group #: _____

ID #: _____

ID #: _____

Client's Relationship
to Subscriber: Self Spouse Child Dependent

Client's Relationship
to Subscriber: Self Spouse Child Dependent

Subscriber's Employer: _____

Subscriber's Employer: _____

If Injured: Date _____ Place: Home or School Work Auto Accident

Nature or Cause of Injury: _____

In case of emergency, local friend or relative to be notified (not living at same address):

Name: _____

Relationship to Client: _____

Home Phone: _____

Work Phone: _____

ASSIGNMENT AND RELEASE:

I hereby authorize my insurance benefits be paid directly to the provider. I am financially responsible for any balance due. I also authorize the provider or insurance company to release any information required for this claim.

SIGNED: _____ DATE _____