Patient Registration

Welcome To Our Office

Today's Date: ________________

Patient's Name (print) ________________________________ Date of Birth ________ Age ____ Gender M F Marital Status S M D Sep W

Address ____________ City ____________ State ____ Zip Code ________

Home Phone: ________________

Work Phone: ________________

Email Address: ________________________________ Cell Phone: ________________

Your Occupation: ________________________ Employer: ________________________

Spouse's Name: ____________________ DOB: ________ Employer: ____________________

Spouse's Address and Phone (If Different) ____

Emergency Contact: ____________________ Phone: ______________ Cell# ______________

Who referred you to our office? ____

Is your condition due to a work injury? Y N If yes, date of Injury: ____________________

Is your condition due to an automobile accident? Y N If yes, date of Injury: ____________________

Primary Care Physician ________________________ Location: ____________________

Authorization:

I hereby authorize Norfolk County Chiropractic dba James W. Morgan, D.C. to release my medical records to my health plan and any other party so that payment may be made directly on my behalf. I agree that any amount not paid by my health plan is my personal responsibility and is payable at the time of service or immediately upon denial of such benefits from my health plan.

Signature: ________________________________ **Date:** ____________________

For Office Use Only

Health Plan: ____________________ ID # ____________________ Effective: __________

Subscriber: ____________________ DOB: ________ Secondary Plan: ____________________

Copayment $ __________ Deductible $ __________ Office visit limit/yr __________

Does this plan require TPA authorization? Yes No ASHN Optum Healthways

Authorization required at the time of the ______ visit. Send claims to: ____________________