Marty Chiropractic – Excelsior, Inc.
REGISTRATION FORM

Today's Date____/____/____

PATIENT INFORMATION (Please give your Drivers License/ID to receptionist)

Patient's Last Name	First	Middle	Marital Status: ☐ Single ☐ Married ☐ Divorced

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	Former Name	Birth Date / /	Age	Sex ☐ M ☐ F

Street Address	City	State	ZIP Code	Social Security: / /	Home Phone

Email Address	Work Phone

Occupation	Employer	Cell Phone No

Chose Clinic Because/Referred to Clinic by: ☐ Dr. ☐ Yellow Pages ☐ Friend - Name: ☐ Social Media ☐ Close to Home/Work ☐ Family-Name:

What type of care do you desire? ☐ RELIEF CARE ☐ CORRECTIVE CARE ☐ WELLESS CARE

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Marty Chiropractic to release any information required to process my claims.

X

PATIENT/GUARDIAN SIGNATURE DATE