New Patient Registration

Chiropractic Health Group, PC   Canton, MA 02021   781.575.0100

Date____________________________   Home Phone______________________
Cell Phone _____________________

Name ____

Street Address____

City____________________________   State____________________   Zip_________________

Gender [ ]M [ ]F   Age__________ Birthdate__________   SS#________________

Marital Status [ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

How did you hear about our practice?____

Is your condition related to [ ] Illness [ ] Employment [ ] Auto Accident [ ] Other

Person to contact in an emergency_______________________________ Phone______________

Primary Care Doctor____ Phone______________

EMPLOYER

Company Name_______________________________________   Occupation________________

Address____   Phone____________________

City____________________________ State________________________ Zip________________

INSURANCE INFORMATION: If you have health insurance, please provide us with your insurance card so that we may have a copy for your file.

Auto and Worker's Compensation Information   Date of Injury / Accident_____________

Insurance Company Name______________________________

Address_______________Phone______________ClaimNumber___________________________
Who's Car were you in and who is the Insured_________________________

Attorney _________________________________

Address____   Phone______________

PATIENT AGREEMENT, ASSIGNMENT, AND RELEASE

I, the undersigned, have insurance coverage with____ and assign directly to CHG,PC. ________________________________ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature____ Date _________________