

REGISTRATION FORM
TIGGES CHIROPRACTIC AND WELLNESS

Date _____

Name _____ SS# _____

Address _____

City _____ State _____ Zip Code _____

Phone: Home _____ Cell _____ Work _____

Age _____ Date of Birth _____ Marital Status M S W D

Email _____ How many children? _____

Occupation _____ Employer _____

Name of Spouse _____ Occupation _____

Patient's Nearest Relative _____

Relationship _____ Phone _____

Referred by: _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this healthcare office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this healthcare office will be credited to my account upon receipt. However, I clearly understand and agree that I am personally responsible for payment of any services rendered me and charged directly to me. I also understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Initials _____

Please hand the front desk personnel your insurance card so we may make a copy for your file.

Patient's Signature _____ Date ____/____/____

Account _____