PATIENT REGISTRATION FORM

(Please Print and Complete All Items – Read and Sign At Bottom)

Today's date:	PCP:

PATIENT INFORMATION

Patient's Last Name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: / /	Age:	Sex: ❑ M ❑ F	Home phone #: ( )	Cell phone #: ( )

Street address:	City:	State:

ZIP Code:	Social Security no.:	Email Address:

Occupation:	Employer:	Work phone no.: ( )

Referred to clinic by (please check one box):

❑ Dr. ___________________________ ❑ Insurance Plan ___________________________ ❑ Hospital ❑ Family ❑ Close to home/work ❑ Yellow Pages

❑ Other__________________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Policyholder Name:	Birth date: / /	Address (if different):	Home phone no.: ( )
Relation to Patient:	Name of insurance:	Insurance address:	Identification no/ S.S#.:

SECONDARY INSURANCE INFORMATION

Policyholder Name:	Birth date: / /	Address (if different):	Home phone no.: ( )
Relation to Patient:	Name of insurance:	Insurance address:	Identification no/ S.S.#.:

INSURANCE AUTHORIZATION AND ASSIGNMENT (PLEASE READ AND SIGN)

I hereby authorize **Ageonics Medical P.C.** to furnish all necessary information to my insurance carriers concerning my (or my dependent's) illness and treatment and I hereby assign to the physician or supplier all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any co-payments for the office visit as designated by my insurance carrier. I understand that it is my responsibility to ensure that procedures/surgeries are part of my contract with my insurance and I am responsible for payment if my insurance carrier does not cover the designated procedure.

Patient/Guardian Signature *Date*

FOR MEDICARE PATIENTS: I hereby authorize **Ageonics Medical P.C.** to furnish al necessary information to my insurance carriers concerning my illness and treatment, and I hereby assign to the physician or supplier all payments for medical services rendered to me.

Patient/Guardian Signature *Date*

DATE: ______________

NAME:____
FIRST MIDDLE LAST

DO YOU HAVE ANY OF THE FOLLOWING COMPLAINTS:

__ Back Pain __ Headaches __ Muscle Spasm/ Weakness __ Chest Pain

__ Foot Pain __ Neck Pain __ Tingling/ Numbness __ Carpal Tunnel

__ High Blood Pressure __ Other:____

ARE YOU INTERESTED IN THE FOLLOWING:

__ Chiropractic __ Physical Therapy __ Medical Doctor

__Dermatologist __ Nutrition __ Massage

__ Weight Loss __ Allergy Testing __ ADD/ADHD Treatment

__ Hormone Replacement Therapy __ Botox and Cosmetic Fillers (i.e.: Juvéderm)

Can Ageonics Medical, P.C. and contact you in regards to the above interests?

__ YES __ NO

Best Phone Number to Be Reached At: __________________________________

OFFICE USE ONLY:

X-Ray Taken: YES______________ NO ______________

Therapist: _______________________________________

Results: