

Champion Chiropractic

4532 E. Lone Mountain Rd. STE 107

Cave Creek, AZ 85331

480-595-0001

PATIENT REGISTRATION FORM

Date: _____

PATIENT INFORMATION (Please use full legal name, no nicknames)

Last Name: _____ **First Name:** _____ **M.I.** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (____) - _____ - _____

Cell Phone: (____) - _____ - _____

Date of Birth: _____ **Age:** _____ **Sex:** _____ **Social Security #:** _____

Employer Name and Address: _____

Email Address: _____

Emergency Contact: _____ **Phone:** _____

May we thank someone for referring you to our office? _____

GUARANTOR INFORMATION (List person responsible for payment – use full legal name)

Relationship to Patient: Self _____ Spouse _____ Parent _____ Other _____

Last Name: _____ **First Name:** _____ **M.I.** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (____) - _____ - _____ **Date of Birth:** _____

Cell Phone: (____) - _____ - _____

INSURANCE INFORMATION (Please allow receptionist to photocopy insurance card and drivers license)

Insurance Company: _____ **Insured's Name:** _____

Insured's Date of Birth: _____ **Policy/I.D.:** _____