Brewer Chiropractic Clinic
702 IH 20, Suite 100 Arlington, TX 76017
(817) 467-2010

Patient Registration Form

Name _____ SS#_____ DL#_____

Address _____ City _____ Zip Code _____

Phone Numbers: Home _____ Cell_____ Work_____ Date of Birth ____ / ____ / _____

Sex: Male Marital Status: Married Are You A Student: No School Currently Attending _____

May we contact you by email? No Email Address _____

Employer _____ Occupation _____ Employer's Address _____

If patient is under 18 years of age, minor lives with: Other

If we need to call you, May we leave a message: Yes At your home with other residents? Yes Voice Mail or Answering Machine Yes

Responsible party for Insurance: Patient Responsible party for Billing: Patient

Spouse / Parent Information

Name _____ SS#_____ DL#_____

Address _____ City _____ Zip Code _____

Phone Numbers: Home _____ Cell_____ Work_____ Date of Birth ____ /____ /_____

Sex: Male Marital Status: Male Are You A Student No School Currently Attending _____

May we contact you by email? No Email Address

Employer _____ Occupation _____ Employer's Address _____

Emergency Contact _____ Phone _____

Primary Insurance Company

Is this for an: Auto Accident

Insurance Company _____ Insurance Phone _____ Insured's Name _____

Insured's Date of Birth _____ Insurance ID #_____ Insurance Group # _____

Insured's SS# _____ Relationship to Patient _____

Secondary Insurance Company

Is this for an: Auto Accident

Insurance Company _____ Insurance Phone _____ Insured's Name _____

Insured's Date of Birth _____ Insurance ID #_____ Insurance Group # _____

Insured's SS# _____ Relationship to Patient _____

Patient Agreement

Assignment and Release to Brewer Chiropractic Clinic

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I hereby authorize the direct payment to you of any sum I now or hereafter owe you by my attorney out of any proceeds of any settlement o my case, and by any insurance company obligated to make payment to me or you based in whole or in part upon the charges made for your services.
3. I hereby authorize the use of this signature on all my insurance submissions.

Patients Signature Date