

Accepting Patients at:
 Knight Chiropractic Center
 within the Rochester Fitness Center
 3313 Chili Avenue Rochester, NY 14624

HealthSource Chiropractic

Donald R. Dudley, DC
 Office: (585) 889-3280
 Fax: (585) 889-7759

REGISTRATION FORM

(Please Print)

Today's Date ____/____/____

PCP _____

PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)		Birth Date / /	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security		Home Phone No. ()
P.O. Box		City	State	ZIP Code			
Occupation		Employer			Employer Phone No. ()		
Chose Clinic Because/Referred to Clinic by (Please check one box) <input type="checkbox"/> Dr. _____ <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital							
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home/Work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____							

Other Family Members Seen Here _____

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)		Home Phone No. ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Occupation	Employer	Employer Address		Employer Phone No. ()
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Please indicate primary insurance <input type="checkbox"/> Blue Choice <input type="checkbox"/> Preferred Care <input type="checkbox"/> No Fault <input type="checkbox"/> Worker's Compensation <input type="checkbox"/> Aetna				
<input type="checkbox"/> United <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Via Health <input type="checkbox"/> Medicare <input type="checkbox"/> Other _____ (Please provide coupon)				

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment \$
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					
Name of Secondary Insurance (if applicable)			Subscriber's Name	Group #	Policy #
Patient's Relationship to Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____					

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ()	Work Phone No. ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize HealthSource Chiropractic or insurance company to release any information required to process my claims.

X _____
 PATIENT/GUARDIAN SIGNATURE DATE