

**REGISTRATION INFORMATION**  
**(PLEASE PRINT)**

Date \_\_\_\_\_ Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Patient \_\_\_\_\_

Last Name

First Name

Initial

Responsible Party (if a minor) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced  
 Employed  Full-Time Student  Part-Time Student Patient's School Name \_\_\_\_\_

Patient Employed By \_\_\_\_\_

Business Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse (or responsible party) Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Business Name and Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Do you have Medical Insurance?  Yes  No If yes,

Name of Primary Insurer \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of Secondary Insurer \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Would you like to receive informational emails?  Yes  No Email Address \_\_\_\_\_

Would you like to receive information regarding nutritional supplements?  Yes  No

Any specific supplements or conditions? \_\_\_\_\_

In case of emergency, who should be notified? \_\_\_\_\_

Phone # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Please list other doctors you have seen in the past 5 years:

1. \_\_\_\_\_ City/State \_\_\_\_\_

(General Practitioner, Specialist, or other)

Reason for seeing \_\_\_\_\_

2. \_\_\_\_\_ City/State \_\_\_\_\_

(General Practitioner, Specialist, or other)

Reason for seeing \_\_\_\_\_

How did you learn of our practice? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with \_\_\_\_\_

Name of Insurance Company

and assign directly to Dr. Jerry L. Johnson, DC – Johnson Family Chiropractic Clinic, P.C. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Jerry L. Johnson, DC – Johnson Family Chiropractic Clinic for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If “other health insurance” is indicated in item 9 of the HCFA – 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

\_\_\_\_\_  
Beneficiary Signature

\_\_\_\_\_  
Date