Wardie
Chiropractic & Nutrition
810•714•1672
www.WardieChiro.com info@WardieChiro.com

PATIENT REGISTRATION FORM

Today's Date: _____

Patient Name: _____ **Responsible Party (If minor)** _____
Last First Middle

Street Address: _____ **City:** _____ **State:** _____

Zip Code: _____ **Sex:** ☐ Male ☐ Female **Email Address:** _____

Phone: Home _____ Cell _____ Work _____ **Primary:** ☐ Home ☐ Cell ☐ Work

Age: ____ **Date of Birth:** _____ **Marital Status (circle):** Single Married Widowed Separated Divorced

Your Employer: _____ **Occupation:** _____

Employer City/State: _____ **Phone:** _____

Spouse's Name: _____ **Date of Birth:** _____

Spouse's Employer: _____ **Occupation:** _____

In case of emergency, who should be notified?

Name: _____ **Phone:** _____

Emergency Contact Relationship to you: _____

Do you have out-of-network chiropractic benefits through your health insurance plan? Yes ☐ No ☐

Please Note: Our office is out-of-network with all insurance plans; therefore all charges are due at time of service. If you have out-of-network chiropractic benefits, we would be happy to provide you with a documented receipt of the services rendered by our office for you to submit to your insurance company for reimbursement.

Attention Medicare Patients: We do not and will not perform any services to Medicare patients covered by Medicare (spinal manipulation of the neck or back in an area of chief complaint) and therefore you will **not** receive codes and therefore cannot submit a claim to Medicare. We would be happy to refer you to someone who accepts Medicare if you desire this type of chiropractic care. All other services we provide are not billable or payable by Medicare via a doctor of chiropractic.

How did you learn of our practice? (please circle)

Friend/Family Member: _____ (name)
Referred by Dr. _____
Event: _____

Internet Search/Website
Yellow Pages
Sign/Live in the area
Direct Mail
Other _____

*By signing I agree to receive emails from Wardie Chiropractic & Nutrition regarding offers, appointments, and/or other health related information.

I realize I have the option to unsubscribe at any time. _____ Date: _____