

**REGISTRATION**

Please Print

**SOUTH RIDING FAMILY CHIROPRACTIC CENTER**

4229 Lafayette Center Drive, Suite 1900  
Chantilly, VA 20151

**CONFIDENTIAL**

Date \_\_\_\_\_

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

Patient \_\_\_\_\_

Last Name

First Name

Initial

Email address \_\_\_\_\_

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

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

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

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

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

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

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

Spouse Employed By \_\_\_\_\_

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

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

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Do you have Medical Insurance?  No  Yes => If yes,

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

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

Name of Secondary Insurer (if any) \_\_\_\_\_

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

Medicare  Medicaid Claim ID # \_\_\_\_\_

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

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

**ASSIGNMENT AND RELEASE**

I, (the undersigned), have insurance coverage with \_\_\_\_\_  
Name of Insurance Company

And assign directly to Dr. \_\_\_\_\_ 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.

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

\_\_\_\_\_  
Date

**MEDICARE AUTHORIZATION**

I request that payment of authorized Medicare benefits be made to me or on my behalf to Dr. \_\_\_\_\_  
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 releasing 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 noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

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

\_\_\_\_\_  
Date