

**PATIENT REGISTRATION**

(FOR OFFICE USE) LUND P3

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
 SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Email \_\_\_\_\_ Employer \_\_\_\_\_

**INSURED PARTY/POLICY HOLDER (IF SAME, PLEASE WRITE "SAME")**

X Last Name \_\_\_\_\_ X First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
 SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ X DOB \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Email \_\_\_\_\_ Employer \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Phone # \_\_\_\_\_ Address \_\_\_\_\_  
 Secondary Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
 Phone # \_\_\_\_\_ Address \_\_\_\_\_

**BENEFIT VERIFICATION (OFFICE USE ONLY)**

Date Verified \_\_\_\_\_ Effective Date \_\_\_\_\_ Ins. Contact \_\_\_\_\_ Ref # \_\_\_\_\_  
 Co-ins/Co-pay: In Network \$ \_\_\_\_\_ Out of Network \$ \_\_\_\_\_  
 Deductible: In Network \_\_\_\_\_ Met \$ \_\_\_\_\_ Out of Network \_\_\_\_\_ Met \$ \_\_\_\_\_  
 Out of pocket limit/max \$ \_\_\_\_\_ / \_\_\_\_\_ Met \$ \_\_\_\_\_ / \_\_\_\_\_  
 Limit: Visits \_\_\_\_\_ Amount Max \$ \_\_\_\_\_ # used in 2015 \_\_\_\_\_ Chiropractic Y N  
 Chiropractic combined w/ PT? Y N Precert? Y N Auth # \_\_\_\_\_ Work Comp? Y N  
 ACN OR AUTHORIZATION REQUIRED: \_\_\_\_\_  
 Additional Notes: \_\_\_\_\_  
 Physical Therapy Combined With: \_\_\_\_\_  
 MD Scripts required: \_\_\_\_\_ Ionto covered? (97033) \_\_\_\_\_  
 MD Referral/PCP: \_\_\_\_\_ Surgery Date \_\_\_\_\_  
 BodyPart(s)/Condition: \_\_\_\_\_  
 X Emergency Contact: Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
 X Who may we thank for referring you to our office? \_\_\_\_\_

*Patient Authorization: I understand that I am responsible for all charges incurred by myself or my family regardless of insurance coverage and that payment is due at the time services are rendered. If my account required servicing by a collection agency or by an attorney, I understand that I will be liable for the collection fees, attorney's fees and applicable other costs.*

X PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_