

CAMILLUS CHIROPRACTIC OFFICE

315-487-2225

NEW PATIENT REGISTRATION FORM

First Name: _____ **MI** _____ **Last Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip** _____

Home Phone: _____ **Work Phone** _____ **Cell Phone:** _____

E-Mail Address: _____ **Sex:** M or F **Marital Status:** _____

Occupation: _____ **Social Security#** _____ **Birthday:** / /

Driver License# _____ **License State:** NY or Other _____

Spouse Name: _____ **Phone:** _____

Patient's Employer: _____ **Address:** _____

Emergency Contact Person: _____ **Phone:** _____

Primary Physician: _____ **Address:** _____

How you heard about The Camillus Chiropractic Office (check any that apply)

- | | |
|---|--|
| <input type="checkbox"/> Dr.'s Recommendation | <input type="checkbox"/> Friend's Recommendation |
| <input type="checkbox"/> Advertisement | <input type="checkbox"/> Prior Injury Treated Here |
| <input type="checkbox"/> Plaza Location (signs) | <input type="checkbox"/> Other |

***** PLEASE PRESENT INSURANCE CARD TO BE COPIED FOR YOUR FILE *****

THANK YOU

Check if you are () Privately Insured () No-Fault () Worker's Compensation

Please fill in this section if your injury is Worker's Compensation/ Work Related

Insurance Carrier: _____ WCB # _____

Address: _____ CC # _____

Phone: _____ Contact Person (Case Manager) _____

Injury Date: / / AM or PM Reported Injury: YES or NO

How did Injury Occur? _____

Please fill in this section if your injury is No-Fault/Auto Related

Insurance Carrier: _____ Claims # _____

Address: _____ Phone # _____

Name of Insured: _____ Policy # _____

Injury Date: / / AM or PM Reported Injury: YES or NO

Contact Person(Claims Adjuster) _____ Phone # _____

Please fill in this section if you are covered by group Private/Major Medical Insurance

Insurance Carrier: _____ Policy # _____

Address: _____ Phone # _____

Name of Policy Holder: _____ Policy Holder SS # _____

Policy Holder Date of Birth / /

Date: / / | Patient/Guardian Signature: _____