Patient Registration

20930 108th Ave SE
Kent, WA 98031
P: (253) 856-8868
F: (253) 856-3654

Information on Patient:

Full Name _____Would like to be called_____

Address _____ City _____ State_____ Zip_____

Home Phone Number _____ Cell Phone Number_____

SSN#_____-_____-_____ Driver's License #_____ Marital Status: S / M / D / W

Date of Birth ***(must fill out)***_____-_____-_____Employer_____

Date of Injury_____-_____-_____Email Address_____

Information on Primary Insurance Policy: *(optional if we photo copied the card)*

Insurance Company _____ ID# _____ Group # _____

My account will be paid by Cash Insurance Work Comp. Personal Injury Medicare Other

Have you ever received Chiropractic Care Y /N If Yes, When? _____Where?_____

How did you hear about us?

Internet_____ Referal_____Newspaper_____Phonebook_____

In case of emergency

Contact Name_____ Phone Number_____

I hereby authorize and request my insurance company to pay directly to the Doctor the amount due on my claim for the services rendered to me or my dependents. I hereby authorize the Doctors of Back to Health Chiropractic and whomever they may designate as the assistants to administer care as they deem necessary. I understand that there is no guarantee of results from this care. I understand that I'm responsible for all cost of chiropractic treatment regardless of insurance coverage.

Patient Signature_____Date_____Parent/Guardian_____