PATIENT REGISTRATION FORM

PATIENT INFORMATION				
PATIENT'S NAME:		DATE OF BIRTH:	GENDER (CIRCLE): M F	
ADDRESS:		CITY:	STATE:	ZIP:
HOME PHONE:	WORK PHONE: EXT:		CELL PHONE:	
SOCIAL SECURITY #:	EMAIL ADDRESS:			
EMPLOYER:	OCCUPATION:		EMPLOYER PHONE:	
EMERGENCY CONTACT:		RELATION:	CONTACT PHONE:	
Thomas Nicolla Consulting Services will NOT share your information with any other company or third party. By providing your email address, you consent to receiving email communication and patient statements. By providing phone numbers above, I am granting permission to contact me at any of those noted.				

PHYSICIAN INFORMATION	
REFERRING PHYSICIAN:	DIAGNOSIS:
IS YOUR INJURY? (CHECK ONE) ☐ WORK RELATED ☐ AUTO RELATED ☐ MOTORCYCLE ☐ OTHER?	
DO YOU HAVE A FOLLOW UP SCHEDULED WITH YOUR DOCTOR? (CIRCLE): YES NO	
ARE YOU CURRENTLY SEEING A CHIROPRACTOR FOR THIS INJURY? (CIRCLE): YES NO	
ARE YOU CURRENTLY BEING SEEN AT HOME FOR ANY HEALTH CARE SERVICES? (CIRCLE): YES NO	
HAVE YOU SEEN A PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, SPEECH THERAPIST OR CHIROPRACTOR IN THE PAST YEAR? (CIRCLE): YES NO	

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)		
INSURANCE COMPANY:		
NAME OF INSURED:	MEMBER #:	GROUP #:
SUBSCRIBER'S SOCIAL SECURITY #:	DATE OF BIRTH:	RELATION:
SECONDARY INSURANCE (IF APPLICABLE):		
NAME OF INSURED:	MEMBER #:	GROUP #:
SUBSCRIBER'S SOCIAL SECURITY #:	DATE OF BIRTH:	RELATION:

WORKERS COMP			
IS THIS A WORKERS' COMPENSATION CASE? (CIRCLE): YES NO		IF YES, EMPLOYER AT TIME OF INJURY:	
WORKERS' COMP INSURANCE CARRIER:		CARRIER ADDRESS (IF APPLICABLE):	
EMPLOYER ADDRESS:			
CASE MANAGER NAME:		PHONE NO:	
CARRIER CASE #:	WCB #:	DATE OF INJURY:	LAST DAY AT WORK:

AUTOMOBILE ACCIDENT	
IS THIS A NO FAULT CASE (AUTOMOBILE ACCIDENT)? (CIRCLE): YES NO	DATE OF INJURY:
IF YES, NO-FAULT INSURANCE COMPANY:	
INSURANCE COMPANY ADDRESS:	
CASE MANAGER NAME:	PHONE NO:
CLAIM #:	POLICY #:

AKNOWLEDGEMENT

I acknowledge that the above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible all charges not paid by said insurance, including any co-payments (which I agree to pay prior to service provided), deductibles, coinsurance as well as any charge for no show and cancellation of appointments. In the event of default or if the account is referred to an attorney or collection, the undersigned agrees to pay for any collection or attorney's fees incurred as a result of delinquency.

Patient/Guardian signature Date