HEALTH CHECK ~ PATIENT REGISTRATION FORM

Please print legibly

All information is strictly confidential and will be used for insurance and billing purposes only.

A) Name____ Home Phone:______________________

First Middle Last Mobile Phone: ______________________

Address: ____ Date Of Birth: ___________________

City: ____ State: ______ Zip: ____________________

Age: ____________ Soc. Sec. Num: _______________ Marital Status: S / M / D / W

Email: _______________________________________

B) Employer: ____

Phone: _____________________________________

C) Insurance Carrier: ___________________________ ID Number: _________________________

D) Auto / Personal Injury / Workmen's Comp. Date of Injury:________ State: ________

Body Part: ___________________________ Insur. Comp: __________________________

Claim #: ____________________________

Contact Person: ____________________________ Phone: _______________________

Do you have a lawyer? (y/n) ____ Lawyer’s name: ________________________ Phone: _________

I, the undersigned, give Health Check, Inc. and its employee's full authorization to release any and all personal and medical information about me that is needed and assignment of my insurance benefits to them. I hereby authorize Health Check, Inc. to release to my insurer/insurance carrier such information that is required for completion and payment(s) of my claim(s) submitted by Health Check, Inc. for services rendered. I authorize my insurance carrier to pay and or make payment(s) to be made directly to the above named Health Check, Inc. for any and all services rendered, otherwise payable to me. I understand that if I do not give at least 8 hour notice about canceling my appointment or that if I do not show up for my appointment that my insurance will be billed for my missed appointment. I also know that 1 am fully responsible for any and all charges, services rendered, and payment(s) that are not covered by my insurance, including co-pays, deductibles, no shows, and balances in full to Health Check, Inc. for services rendered at and associated with Health Check, Inc. on the above mentioned date(s).

Signature of Patient: ____ Date:____________