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 know that I am fully responsible for any and all charges, services rendered, and payment(s) that are not covered by my insurance, including co-pays, deductibles, 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:_____