

HERMEN HEALTH, PLLC REGISTRATION FORM

DR. JILL HERMEN, D.C.

Today's date:				DR: HERMEN, D.C.			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Spouse's name?	SS#:	Fax #: ()		Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Cell phone #: ()		Home phone #: ()		
E-mail:		City:		State:		ZIP Code:	
Occupation:		Employer:			Office #: ()		
Chose clinic because/Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Patient
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date: / /	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:		Employer:	Employer address:			Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> Major Medical	<input type="checkbox"/> Worker's Comp	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Auto Accident	
<input type="checkbox"/> Campus	<input type="checkbox"/> Camp VA	<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>			
Subscriber's name:		Subscriber's S.S. no.:	Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Hermen Health, PLLC or Dr. Jill Hermen, DC to release any information required to process my claims.</p>				
<hr style="width: 100%;"/> <i>Patient/Guardian signature</i>			<hr style="width: 100%;"/> <i>Date</i>	