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:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Spouse's name?	SS#:	Fax #: ( )	Birth date: / /	Age:	Sex: ❑ M ❑ 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):	❑ Dr.	❑ Insurance Plan	❑ Patient

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ 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? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Major Medical	❑ Worker's Comp	❑ Medicaid	❑ Medicare	❑ Auto Accident

❑ Campus	❑ Camp VA	❑ Other	❑	❑

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ 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.: ( )

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.

Patient/Guardian signature *Date*