PATIENT REGISTRATION FORM

Date: _____

Last Name: _____ First: _____ S.S#_____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M / F

□ Single □ Married □ Other Occupation: _____

Phone Number: Home: _____ Cell: _____ Email: _____

Emergency Contact: Last _____ First _____

Relationship to Patient: _____ Phone: _____ Alt: _____

INSURANCE INFORMATION

Person responsible for account: Last: _____ First: _____

Relationship to Patient: Self / Spouse / Child / Other Date of Birth: _____

Address (if different from above): _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Subscriber ID #: _____ **Group #:** _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I have insurance coverage and assign payment directly to DeCicco Acupuncture LLC. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the acupuncturist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submission. If the patient is a minor, I as a legal guardian give consent for treatment for this and future services rendered.

Responsible Person/Patient Signature: _____ Date: _____