COHEN CHIROPRACTIC CENTER

238 South Arroyo Parkway, Unit #140, Pasadena, California 91105
Phone: (626) 449-9000 – Fax: (626) 449-9939 – Email: cohenchiro@gmail.com

PATIENT REGISTRATION FORM

PATIENT NUMBER (Office Use Only): ______________________ Date of Birth: ____/____/________

Last Name: ____________ First name: ____________ Age: ________

Sex: Male ☐ Female ☐ Title (circle one): Mr. Mrs. Ms. Miss Dr. Other: ________

Address: ____________ Apt.#: ______ Primary Language: ________

City: ____________ State: ______ Zip: ________

Home Tel: ( ) ________ Work Tel: ( ) ________ Ext.: ______ Cell: ( ) ________

EMAIL: ________________________

Social Security No.: ________ Driver's License #: ________ State: ________

Employer: ________ Occupation: ________

Employer's Address: ________________________

City: ____________ State: ______ Zip: ________

Referred by: ________________________

Emergency Contact:

Name: ________ Relationship: ________ Phone: ( ) ________

INSURANCE INFORMATION: PLEASE COMPLETE THIS SECTION IF YOU WOULD LIKE US TO BILL YOUR INSURANCE FOR YOU.		
Subscriber Name:	Health plan:	
Subscriber ID#	Group ID #:	Relationship to subscriber:
Subscriber's Employer's address:		
City:		State: Zip:
Have you met your insurance deductible? Circle one: YES / NO		
Insurance Co-Payment (if known): $		Do you have other health insurance? Circle one: YES / NO
Primary Care Physician Name:		Physician's Phone: ( )

THANK YOU.

We appreciate the trust you have placed in us. We will make every effort to honor that thrust by providing the quality of care that you require and deserve.

If you have insurance coverage, we will be glad to assist you with your claim; however, you are responsible for any charges that are not paid by your insurance company. Payment is expected as services are rendered unless alternate arrangements are made in advance. If you have any questions, please check with the receptionist. Thank you for your cooperation.

Signature: ________________________ Date: ________________