

Infinite Healing Center

6638 E. Baseline Rd. #103. Mesa, AZ 85206 (480) 985-7070

REGISTRATION FORM

PATIENT INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____ / _____ / _____ Age: _____

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

Home Phone: _____ Cell Phone: _____

Insured Social Security # _____ - _____ - _____ Insured Drivers License # _____

Occupation: _____ Employer Name: _____ Work No. _____

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

E-mail address: _____

Emergency Contact Name: _____ Phone No. _____

Nearest friend/relative not living with you: _____ Phone No. _____

Whom may we thank for referring you? Patient Name: _____

Ins. Company _____ Attorney _____ Doctor Name: _____

Yellow Pages _____ Mailer/Flyer _____ Patient Re-activation _____ Other: _____

PATIENT INSURANCE INFORMATION *Please leave a copy of your insurance card so we may verify benefits

Insurance Company: _____ Name of Insured: _____

Relationship: Self Spouse Child Other _____

ACCIDENT INFORMATION

Is this condition due to an accident? Yes No Date of Accident: _____

Type of accident Auto Work Home Other _____

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other _____

Attorney Name (if applicable) _____ Phone #: _____

PATIENT ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and
(NAME OF INSURANCE COMPANY)

Assign Dr. _____ and Infinite Healing Center all medical 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 doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

(SIGNATURE OF INSURED OR GUARDIAN)

(DATE)