PICO
Family Chiropractic Center

PATIENT REGISTRATION

Should we thank any individual for referring you to Dr Pico?		Date	
Full Name	DOB	Age	☐ Male ☐ Female
Address			
Home Telephone ☐ Primary Contact	Work Telephone ☐ Primary Contact	Mobile ☐ Primary Contact	
Social Security Number	Email Address		
Emergency Contact Name	Relationship	Emergency Contact Number	

INSURANCE INFORMATION

Primary Insurance Carrier	Group Number	ID Number
Primary Insured	Employer Name	
Business Address		
Employee Social Security Number	Employee Date of Birth	

FINANCIAL RESPONSIBILITY

Person Responsible for Account: ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Name	Social Security Number
Address	
Telephone	Email Address

CREDIT CARD PAYMENT AUTHORIZATION

I _____, hereby authorize Pico Family Chiropractic DC, PC and/or the staff at 162 W 56th St Ste 302, New York, NY 10019 to charge my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify Pico Family Chiropractic DC, PC of any changes regarding this credit card authorization.

Name on Card	Signature/Date	
Credit Card Type ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express	Credit Card Number:	
Expiration Date	Security Code	Billing Zip Code

I attest, to the best of my knowledge, the above information is accurate and true.

*Signature:*_____ *Date:*_____