Pico Family Chiropractic Center

Patient Registration

Should we thank any individual for referring you to Dr. Pico?		Date	
Full Name	DOB	Age	Gender
Address			
Home Telephone	Work Telephone	Mobile	
Social Security Number	Email Address		

Insurance Information

Primary Insurance Carrier	Group Number	
ID Number	Primary Insured	Employer Name
Secondary Insurance Carrier	Group Number	
ID Number	Secondary Insured	Employer Name

Financial Responsibility

Person Responsible for Account: ☐ Self ☐ Spouse ☐ Parent ☐ Other (Please Specify):	
Name	SSN
Do you have an HRA account? ☐ Yes ☐ No	Do you have a Flex Spending account? ☐ Yes ☐ No
Telephone	Email Address

Credit Card Payment Authorization

I _____, hereby authorize Pico Family Chiropractic DC, PC and/or the staff at 162 W 56th Street Ste 205, 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	Credit Card Type: ☐Visa ☐ Mastercard
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: _____