

**DX** \_\_\_\_\_  
Dr. Seeman to fill in

## Registration for Insurance Clients

Client Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt#

City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer: \_\_\_\_\_

**PRIMARY INSURANCE INFO:** (indicate by check mark if same as above)

Insurance Company/3<sup>rd</sup> Party Payer: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

SS# \_\_\_\_\_ Insurance Co. Phone: \_\_\_\_\_

ID#: \_\_\_\_\_ Group# \_\_\_\_\_

## Registration for Insurance Clients

(Asterisked (\*) fields are optional)

Person to contact in case of emergency: \_\_\_\_\_  
Name

Relationship to you \_\_\_\_\_ Phone \_\_\_\_\_

Your Occupation: \_\_\_\_\_ How long on present job? \_\_\_\_\_

E-mail: \_\_\_\_\_ Place of birth: \_\_\_\_\_

Are you:

Married/Partnered

Single

Separated

Divorced

Widowed

Living with spouse/partner?  Yes  No If yes, how long? \_\_\_\_\_

\*Ethnicity: \_\_\_\_\_ Religious/Spiritual Orientation: \_\_\_\_\_

\*Do you have a work related problem?  Yes  No

\*Are you currently on:

Workers' compensation?

SSI?

State disability?