Back & Neck Wellness Center

**Dr. Bonnie Langrehr** ▪ 4222 Milwaukee Street, Suite 83 ▪ Madison, WI 53714 608-222-4244

# Patient Registration

**Patient Information**: Date: ___/___/_____

Name: _____ D.O.B.: ___/___/____

Address: _____ Cell Phone: (____) _____-_____

City: _____ ST: _____ ZIP: _____ Home Phone: (____) _____-_____

E-mail: _____ Referred by? _____

Occupation: _____ Employer: _____

What type of physical activity/posture does your job involve? (prolonged sitting, standing, bending, etc.)

_____

Spouse's Name: _____ D.O.B.: ___/___/____

Spouse's Employer: _____

**Insurance Information**: □-Group Health Plan □-Medicare □-Worker's Comp □-Auto Accident □-Cash

Insurance Name: _____ Phone: (____)_____-_____

Subscriber ID: _____ Policy #: _____ Group #: _____

Insurance Address: _____

City: _____ ST: _____ ZIP: _____

Date of Accident: ___/___/____ Claim #: _____

Secondary Insurance Name: _____ Phone: (____)_____-_____

Subscriber ID: _____ Policy #: _____ Group #: _____

Insurance Address: _____

City: _____ ST: _____ ZIP: _____

**Patient Agreement**: ***I, the undersigned, have insurance coverage with _____ and assign directly to Dr. Langrehr 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 payment of benefits. I authorize the use of this signature on all my insurance submissions.***

- ➔ **Printed Name: _____**
- ➔ **Signature: _____ Date: ____/____/_____**