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|  **MEMBER INFORMATION** |
| First Name:  | Last name:  | DOB:  |
| E- mail: | Gender:Male Female Other  |
| Cell phone number: | Home phone number: |  |
| Address:  |
| Marital Status: | PCP: | Preferred Pharmacy: |
| How did you hear about us? Referral PATH ad Online search Base Gym  |
| Reason for visit: LIFE\*MOD Orthopedics Primary Care  |
| How would you like to be contacted? Phone E-mail  |
| Interested in other services:  **Vitamin B12 shot Cortisone shot Orthotics PRP (Ortho) PRP (Facial) PRP (Hair)**  |
| LIFE\*MOD DOes not accept insurance.HOWEVER, BLOODWORK AND PRESCRIPTIONS MAY BE COVERED directly by your insurance carrier. cHECK WITH YOUR insurance policy. |
| INSURANCE INFORMATION(For informational purposes only) |
| Person responsible for bill: | Birth date:  | Address (if different): | Phone number: |
| Occupation:  | Employer:  | Employer address:  | Employer phone number: |
| Primary Insurance:  | Subscriber’s name:  |  Birthdate:  |
|  **IN CASE OF EMERGENCY**  |
| Name:  | Relationship to patient:  | Home phone number:  | Cell phone number:  |
| * **The above information is true to the best of my knowledge.**
* **I understand that I am financially responsible for any balance that is due at the date of service rendered.**
* **I understand that if I do not cancel my appointment giving 24 hour notice, I will be charged a fee of $50.00.**

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**Registration Form**