|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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.**   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient/Guardian signature Date | | | | | | | | |

**Registration Form**