TECUMSEH CHIROPRACTIC CENTER, INC

DR. CALVIN J TUTTLE, D.C.
402 E. CHICAGO BLVD. • TECUMSEH, MI 49286

PATIENT REGISTRATION

Date: _____

Name _____ Birthdate _____ SS# _____
(First) (M.I.) (Last)
Address _____City _____State _____Zip _____
Home Phone _____ Work Phone_____ Cell Phone _____
Driver's License # _____ E-Mail _____Number of Children _____
Employer_____ Job Description _____ Years on Job _____
Employer Address _____ City _____ State ____ Zip _____
Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell

How did you hear about our office? ☐ Sign ☐ Yellow Pgs. ☐ Referral by:_____

Prim. Health Insurance _____ Secondary Ins._____Family Physician _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Gender: ☐ Male ☐ Female
Spouse's Name _____DOB_____
Name of person responsible for this account:_____Relationship to Patient _____
Phone #_____Address _____City _____ State Zip _____

AUTHORIZATION

The undersigned herby grant to Dr. Calvin Tuttle, the authority to release and obtain information regarding my past and/or present health condition, from other entities.

I hereby authorize and direct insurance benefits to be paid directly to Dr. Calvin J Tuttle.

A copy of this document shall have the same authority as the original, which shall remain in the file of Dr. Calvin J Tuttle.

The undersigned also grants to any entities authority to release documents requested by Dr. Calvin J Tuttle.

_____ _____
Signature Date

_____ _____
Social Security Number Date of Birth