



REGISTRATION (Please print)

Name _____ " Female " Male
SSN _____ Birthdate _____ Age _____
Address _____
City/State/Zip _____
Telephone (H) _____ (W) _____ (Cell) _____
" Single " Married " Partnered " Divorced " Separated " Widowed

Referred By: _____

Emergency Contact: Name _____
Relationship _____ Telephone _____

Employer: Name _____
Address _____
Telephone _____ Occupation _____

Insurance: Please Choose One

" BCBS PPO " Northwestern Student Aetna " Medicare (Dr. Michael Raida Only) " Self-Pay

Secondary:

Your signature below authorizes the release of any medical or other information necessary to process your insurance claims. Your signature below also authorizes payment of medical benefits to your provider for services rendered.

Signature _____ Date _____