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Registration (Please Print)

Date _____

Last Name _____ First Name _____ MI _____

Address 1 _____

City _____ State _____ Zip _____

** Referred By _____ Of _____

Your Email address _____

Insurance Provider _____ Policy # _____ Group # _____

Primary Care Physician _____

Other _____

** DOB _____ Age _____ Sex Female Male

Occupation _____ Employed By _____

Spouse's Name _____ Spouse's Phone # _____

Contact in Case of Emergency _____ Phone # _____

Is your injury accident related? _____ If Yes, how? _____

Attorney name and phone# _____

Home # _____ Work # _____ Work Ext _____

Cell # _____ Social Security # _____

I, the undersigned, assume all responsibility for all charges incurred during my visits. I also understand these charges will be paid at the time services are rendered. In addition, Jeffrey P. Haggquist, DO, PLLC, and The Flexibility, Sports & Rehabilitation Clinic will provide a sales receipt that details my charges, procedures and diagnoses at the end of each visit.

Signature of Patient, Parent, Guardian or Personal Representative

Date