The Salerno Center
Center for Complementary Medicine

PATIENT REGISTRATION

Which Doctor Are You Seeing?		Date	
Full Name	DOB	Age	☐ Male ☐ Female
Address			
Home Telephone	Work Telephone	Mobile	
Social Security Number	Email Address		
Emergency Contact Name	Relationship	Emergency Contact Number	

GETTING TO KNOW YOU

How did you hear about The Salerno Center ?
Should we thank any individual for referring you to The Salerno Center?

INSURANCE INFORMATION

☐ Medicare

Primary Insurance Carrier	Group Number	ID Number
Primary Insured	Employer Name	
Business Address		
Employee Social Security Number	Employee Date of Birth	

FINANCIAL RESPONSIBILITY

Person Responsible for Account: ☐ Self ☐ Spouse ☐ Parent ☐ Other	
Name	Social Security Number
Address	
Telephone	Email Address

CREDIT CARD PAYMENT AUTHORIZATION

I _____, hereby authorize The Salerno Center to charge my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify of any changes regarding this credit card authorization.

Name on Card	Signature/Date	
Credit Card Type ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover	Credit Card Number:	
Expiration Date	Security Code	Billing Zip Code

I attest, to the best of my knowledge, the above information is accurate and true.

Signature: _____ *Date:* _____