18510 MEYERS ROAD
DETROIT, MICHIGAN 48235
PH: 313-474-3040 F: 313-474-4101
INFO@CHUNTERHEALTHCARE.COM

REGISTRATION INFORMATION

Date______________ Home Phone (______) __________________ Work Phone (______) __________________

Patient: ____
Last Name First M.I

Sex: ☐ M ☐ F Age:_________ Birthdate:_______-_______-______ Email: ______________________________

Address:_______________________________________ City/State:________________________ Zip:___________

EMERGENCY CONTACT INFORMATION

Name:____

Relationship:____ Phone (_____)______________________________

INSURANCE INFORMATION

Contract Holder:____ Email: _____________________________
Last Name First Name M.I.

Relationship to Patient:____________________________ Employer:_____________________________________

Insurance Company :____ Phone(_____)________________________

Address_______________________________________ City, State_________________________ Zip___________

Contract Number:______________________________________ Group Number____________________________

Effective Date____ Cancellation Date:__________________________

Source of Verification (See Attached Copy)____
(Driver's License, Social Security Card, or Insurance Card)

IF YOU HAVE MORE THAN ONE INSURANCE PLEASE NOTIFY THE OFFICE STAFF.

Carla Hunter MD, PLLC
Payment is authorized upon your receipt of itemized statement for services rendered. Payment of this amount as herein directed, in whole or in part, shall be considered the same as if paid by your company directly to me. I permit a copy of this authorization to be used in place of the original.

____ ______________________________
Signature Date

Rev 050622