

PROVIDER INFORMATION

*****ALL INFORMATION ON THIS PAGE IS REQUIRED*****

Please print legibly or type, with all questions answered.

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Social Security Number _____

Tax ID Number _____ NPI Number _____

E-MAIL _____

Primary Practice Name & Address: _____

Mailing Address (i.e., PO Box) _____

Office Phone _____ Office Fax _____

Do you have additional locations *Y/N _____

*If yes please fill out Location Information Form for each location.

Additional Office Address: _____

Mailing Address for additional offices: _____

2nd Office Phone _____ 2nd Office Fax _____

Chiropractic School Attended _____ Year of Graduation _____

Primary State Initials _____ License Number _____ Expiration Date _____

List all other states in which you **hold or have held** a license:

State _____ License Number _____ Exp. Date _____

State _____ License Number _____ Exp. Date _____

Medicare Provider Number _____ UPIN Number _____

Malpractice Insurance Carrier _____

Policy Number _____ Expiration Date _____