

PROVIDER INFORMATION

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

Please print legibly or type, with all questions answered.

First Name _____ Middle _____ Last Name _____

DOB _____ Gender _____ Chiropractic School _____ Grad yr. _____

SS# _____ - _____ - _____ Individ. NPI (type 1) _____

List any language other than English in which you are fluent _____

Are you a State Association Member _____ (print association name)

E-MAIL: _____

Primary Office Tax ID #: _____ Business NPI (type 2) _____

Primary Practice Name & Address: _____

County: _____

Mailing Address (P.O. Box) _____

Office Phone _____ Office Fax _____

Office Contact Name: _____ Title: _____

Malpractice Insurance Carrier _____ Expiration Date _____

Policy Number _____ Coverage Amount _____

Medicare Provider Number _____ UPIN Number _____

License Number _____ License State _____ Exp. Date: _____

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

Do you have additional locations *Y/N _____ County: _____

Add. Office Tax ID #: _____ Add. Business NPI (type 2) _____

Additional Practice Name & Address: _____

2nd Office Phone _____ 2nd Office Fax _____

2nd Mailing Address (ie: PO Box) _____