Chiropractic Patient Registration

Patient Name____Date of Birth:__________________________

Sex: ___Male ___Female Social Security Number__________________________
Mailing Address____
City__________________________State________Zip____________________
Phone (_____)_______________ Work (_____)_______________ Cell (_____)_______________
E-Mail____

Work Status: ___employed ___unemployed ___disabled ___retired ___student
Workplace: Employer____
Address:____
Job Title:__________________________________How Long Employed?_____________________

Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed ___Minor Child

Spouse's Name:____Cell #________________________________
Spouse's Employer:______________________________________Phone:______________________________

Patient under 18? Print name & phone # of Parent/Guardian:
____

Emergency Contact Name & Phone # ____

FAMILY MEDICAL DR.____

Financial Information
Do you have health insurance? ___yes ___no Insurance Company________________________________
Who is the insured?_________________________ID#______________________Group#________________
Relationship to patient (if other than self)____
Do you have a 2nd insurance? ___yes ___no Insurance Company________________________________
Who is the insured?_________________________ID#______________________Group#________________
Method of Payment: Cash___ Check___ Credit Card____
Person responsible for this account:___________________________________
We cannot file your insurance if this section is not completed and the bill will be sent to you.

Accident Information
Is this visit due to an accident? ___yes ___no If yes, what kind? ___Auto ___Work ___Other
Accident date:__________ Has it been reported? ___yes ___no If yes, to whom?_________________________
Insurance company of vehicle you were in:_______________________ **Policy #:**_____________________

Assignment, Consent of Care and Release
I certify that I (or my dependent) have insurance coverage with________________________and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY AND/OR ATTORNEY TO PAY DIRECTLY TO BACK AND NECK PAIN CENTER, PC INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

A patient coming to the doctor gives their permission and authority to care for the patient in accordance with appropriate tests, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor will not provide specific healthcare, if they are made aware of such problems prior to treatment. It is the responsibility of the patient to make it known to the doctor.

____ ____________________
PATIENT SIGNATURE OR PARENT/LEGAL GUARDIAN Date

HIPPA - I was given the opportunity to receive and review the office's *Patient Notice of Privacy* policy.

____ ____________________
PATIENT SIGNATURE OR PARENT/LEGAL GUARDIAN Date