

**PATIENT REGISTRATION**

Today's Date \_\_\_\_\_

Please complete all fields of the form. Indicate N/A for questions that do not apply. Thank you.

Patient: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home PH: \_\_\_\_\_ Cell PH: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ # of Children \_\_\_\_\_

Who is responsible for payment?  Self  Spouse  Parent  Other \_\_\_\_\_

Insurance Company(s): \_\_\_\_\_

Insured Relationship to Patient:  Self  Spouse  Parent  Other \_\_\_\_\_

Insured Name: \_\_\_\_\_ Birth Date \_\_\_\_\_

**Purpose of this appointment and list your complaint(s):** \_\_\_\_\_

Date injury occurred or condition started: \_\_\_\_\_

How did injury/condition occur?  Auto  On the Job  Other \_\_\_\_\_

What makes your condition feel **Better**? \_\_\_\_\_

What makes your condition feel **Worse**? \_\_\_\_\_

Other Doctors seen for this condition: \_\_\_\_\_

Have you been treated for any health condition in the last year?  No  Yes, Explain: \_\_\_\_\_

**X-RAYS FROM THIS OFFICE ARE SENT TO BE READ BY AN X-RAY RADIOLOGIST:**

I understand that in the event x-rays are taken, that the services of a qualified radiologist from *Diagnostic Imaging Inc.* will be utilized for a second opinion or further interpret my x-rays and give consent for their release.

**PROFESSIONAL SERVICES CONSENT, RELEASE OF INFORMATION & INSURANCE INFORMATION:**

I authorize the assignment of insurance benefits to the chiropractor or chiropractic office. I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to my account upon receipt. I understand I may receive a billing statement for: insurance denial, professional fees that have been applied to my deductible, co-payments, or any balance due stated by my insurance company as my responsibility. In the event that I receive payment for any services I agree to promptly remit payment to the chiropractor or chiropractic office. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable unless other arrangements were made in writing. I understand I am responsible for collections fees, court costs and reasonable attorney fees to collect unpaid accounts.

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistants to administer treatment, physical examinations, x-ray studies, chiropractic care or any clinic services that he/she deems necessary in my case; and I further authorize him/her to disclose all or any part of my patient health record to any person or corporation which is or may be liable under a contract to the clinic or to the patient or to the family member or employer of the patient for all or part of the clinic's charges, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare fund, or the patient's employer.

Patient /Guardian Signature \_\_\_\_\_

