

PATIENT REGISTRATION

Name: (Last) _____ (First) _____ (MI) _____ (Jr., Sr., etc.) Sex: M or F
Street Address: _____ Apt./Space: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Marital Status: _____

CONTACT INFORMATION (Check the box next to the best contact number)

Home phone: _____ Work Phone: _____ Cell Phone: _____
Email address: _____
EMERGENCY CONTACT: _____ Relation: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

PARENT / RESPONSIBLE PARTY FOR PAYMENT: _____ Date of Birth: _____
Address: (If different from above) _____
City: _____ State: _____ Zip Code: _____ Phone: _____

INSURANCE INFORMATION

Primary Ins: _____ Insured Name: _____ DOB: _____
Secondary Ins: _____ Insured Name: _____ DOB: _____
On the job injury? YES NO
Worker's Comp Insurance Co. _____ Date of Injury: _____ Claim #: _____ Adjuster's Name _____
Auto Accident? YES NO _____ Date of Injury: _____ Claim #: _____ Adjuster's Name _____
Attorney's Name: _____ Attorney's Phone: _____

PREVIOUS THERAPY INFORMATION

Have you received any other Therapy Services this calendar year? YES NO
Have you received, or are you currently receiving Home Health Therapy? YES NO
If yes, please provide dates: _____ and the name of Home Health Agency: _____
Have you received, or are you currently receiving Chiropractic Treatment? YES NO

I hereby authorize payment of medical benefits to _____, for services furnished to me. I also hereby consent to have treatment and care as prescribed by my physician and / or recommended by the therapist. I also authorize the therapist to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I HEREBY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED WHETHER OR NOT I HAVE INSURANCE COVERAGE. VERIFICATION OF BENEFITS WE RECEIVE FROM YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF PAYMENT.

Patient or Responsible Party Signature

Date