



PATIENT REGISTRATION

Name: First: _____ MI _____ Last: _____

Sex: M ___ F ___ Date of Birth: _____

Address: Street/PO Box: _____ City _____ State ___ Zip _____

Soc. Sec. # _____ - _____ - _____ Home Phone: _____ Cell: _____ Work: _____

E-Mail: _____ Marital Status: _____

Nearest Relative: Name/City: _____ Phone: _____

Employer: Name/City: _____ Phone: _____

This visit is the result of: Auto Accident ___ Injury ___ Accident on the job ___ Other _____

Have you seen a Chiropractor before? ___ Y / N Name: _____

Who is your Primary Physician? _____ May we contact them regarding your care? Y / N

How Did You Hear About Us? Referred By: _____ Internet ___ Newspaper ___ Other ___

FINANCIAL AGREEMENT

1. INSURANCE: This office will bill my insurance company. I will pay my portion of deductibles and co-payments at the time of services rendered. I hereby authorize my insurance benefits to be paid directly to this office. I also expressly authorize the release of any information necessary to satisfy my claims for services.

2. PAYMENT IN FULL: Payment in full is due at the time services are rendered.

I understand that I am fully responsible to the doctor, or his office, for all health care bills submitted. I agree to pay the doctor immediately upon dispersal of any funds from any sources. An additional finance charge of 1.5% per month (beginning the day of disbursement of funds from any source) will be paid by me on any balance remaining for said services. If I suspend or terminate care, any balance for fees will be immediately due and payable.

Patient/Guardian Signature: _____ **Date:** _____