Registration & Account Information

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

PATIENT INFORMATION

Last Name		First Name		M.I
Age	Date of Birth	Social Security #		Gender ☐ Male ☐ Female
Status ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed				
Street		City	State	Zip code
Work phone Ext.	Home Phone	Cell Phone	Email	
Spouse or Guardian last name		First Name	M.I.	Age

EMERGENCY CONTACT

Last Name	First Name	Relationship	Home Phone	Work Phone	Cell Phone
Last Name	First Name	Relationship	Home Phone	Work Phone	Cell Phone

PATIENT EMPLOYMENT

Employers Name		Occupation	
Address Street	City	State	Zip Code

QUESTIONS

Who referred you to us?
How did you hear about our clinic?
Are you here because you were involved in an auto accident?
Are you here because you were injured at your place of employment?
Are you here because you were involved in any type of accident?
Any other reason you came to this office
Will you be using insurance to supplement payment to our office? If YES, please complete the INSURANCE COVERAGE and INSURED INFORMATION section of this form

INSURANCE COVERAGE

Primary Insurance company	Primary ins. ID#	Primary ins. Group #	Relationship to Account Holder
Secondary Insurance Company	Secondary ins. ID#	Secondary ins. Group #	Relationship to Account Holder

Patient or Guardian Signature

Date

INSURED'S INFORMATION

Last Name	first name	m.i.

street	city	state	zip

employer	age	date of birth	Social Security #	Gender ☐ Male ☐ Female

Relationship to Patient

☐ Self ☐ Spouse ☐ Dependent ☐ Other ______________________________

BENEFITS ASSIGNMENT & INFORMATION RELEASE

I authorize the payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

____
Patient or guardian signature

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

______________________________ ______________________________
Patient or guardian signature Date

CHIROPRACTIC HISTORY

Have you ever been to a Chiropractor before? ☐ Yes ☐ No	If yes Doctor's Name
Date of last chiropractic visit	Reason for care
Date of last chiropractic x-rays	How long were you under care?
Are other family members under chiropractic care? ☐ Yes ☐ No	Who?

WELLNESS COMMITMENT

At this Chiropractic office we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment*, but we do ask for your *cooperative commitment*. Based on a scale of 10% to 100%, please **circle** your personal level of commitment toward obtaining and maintaining health and wellness.

10%--------20%--------30%--------40%--------50%--------60%--------70%--------80%--------90%--------100%