CLINIC REGISTRATION FORM

Name:____ Date: ___________________________

Address: ____ City: _______________ State: ____ Zip: _________

Phone (Home): _______________________________________ Phone (Work): ____________________________________

Cell Phone: ____ Preferred Contact Number: H ☐ W ☐ C ☐

Email: ____ Gender _M ☐ F ☐

Social Security Number: ______________________________ Date of Birth: _____________________ Age: _________

Occupation: ____ Employer: ____

Spouse's Name: _____________________________________ Spouse's Employer:________________________________

Children's Names:____________________________________

General Practitioner____________________________

Address_______________________________________

Phone _________________Currently Under Care? Y / N

Reason____

Eye Doctor______________________________

Address_______________________________________

Phone _________________Currently Under Care? Y / N

Reason____

General Dentist ______________________________

Address_______________________________________

Phone _________________Currently Under Care? Y / N

Reason____

Other Practitioner ______________________________

Address_______________________________________

Phone _________________Currently Under Care? Y / N

Reason____

Chiropractor ______________________________

Address_______________________________________

Phone _________________Currently Under Care? Y / N

Reason_________________Results – Good / Bad_____

Who may we thank for referring you?______________________________

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered 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 me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate, and I give authority for these procedures to be performed. It is understood and agreed the amount paid to the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office, which are due when the service is rendered.

I HAVE READ AND UNDERSTAND THE ABOVE

Patient's/Guardian's Signature: ____ Date: _______________