

PATIENT REGISTRATION

First: _____ Middle Initial: _____ Last: _____

Wishes to be called: _____

Local Address: _____ City: _____ State: _____ Zip: _____

Home Address (if different): _____ City: _____ State: _____ Zip: _____

Home Phone Number (REQUIRED): _____ Cell Phone Number: _____

E-mail: _____

Date of Birth: _____ Social Security Number: _____ Male Female

Marital Status: Married Single Divorced Separated Widowed Spouse's Name _____

Emergency Contact: _____ Relation: _____ Phone Number: _____

Primary Care/Family Doctor's Name: _____ Phone Number: _____

Primary Complaint: _____ Condition Getting: Better Worse No Change

Secondary Complaint: _____ Condition Getting: Better Worse No Change

Currently: Employed Contracted Unemployed Self Employed Retired

Employer: _____ Address: _____ City: _____

State: _____ Zip: _____ Occupation: _____ Title: _____

Work Phone Number: _____ Ext: _____

Method of Payment

Health Insurance (Company _____) Cash/No Insurance.

Automobile Accident/Personal Injury Work Related Injury/Worker's Comp

Primary Insurance Company _____

Subscriber's Name _____ Male Female Date of Birth _____

Social Security Number _____ Relationship to Patient: self spouse parent other _____

Subscriber's Employer _____ Group # _____

Subscriber's ID # _____

Secondary Insurance Company _____

Subscriber's Name _____ Male Female Date of Birth _____

Social Security Number _____ Relationship to Patient: self spouse parent other _____

Subscriber's Employer _____ Group # _____

Subscriber's ID # _____

How did you hear about us? Website BNI Insurance Existing Patient Walk/Drive by Doctor *Individual's name:* _____

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payers and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand and agree that the doctors of Performance Chiropractic Clinic have the right to refuse to accept me as a patient at any time. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

Signature of Patient or Parent of Minor

Date