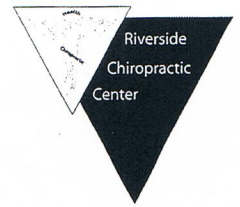


Patient Registration



Date _____

PATIENT INFORMATION

Patient Name _____
First Name Last Middle Initial

Date of Birth _____ Age _____

Address _____

Sex: M F

City _____ State _____ Zip _____

Status: Single Married Divorced

Phone (W): _____ Phone (H): _____

Widowed Minor

Email Address: _____

Number of Children _____

Occupation _____ Patient Employer/School _____

Family doctor name and phone number _____

Reason for visit: _____ When did this problem start? _____

How did you hear about us? _____

ACCIDENT INFORMATION

Is condition due to an accident? No Yes Date of Accident _____

Type of Accident Auto Work Home Other _____

To whom have you made a report of your accident? Auto Insurance Employer Work Comp.

Did you stop work? No Yes How long? When? _____

Attorney Name (if applicable) _____ Phone Number () _____

INSURANCE

Name of Health Insurance Co _____ I.D. Number _____

Name of Insured _____ Relationship to Patient _____

Secondary Insurance _____

Automobile Insurance or Work Comp. Insurance _____

Name of Insured _____ Claim # _____ Policy # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Riverside Chiropractic Wellness Centers, Inc. all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions.

Signature of patient, parent, or guardian
Date _____

Please Print name of patient, parent, or guardian
Relationship to patient _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPPA)

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature

Date