Patient Registration

Riverside Chiropractic Center

Date _____

PATIENT INFORMATION

Patient Name _____ Date of Birth _____ Age _____
First Name Last Middle Initial

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 Please Print name of patient, parent, or guardian

Date _____ 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