CHIROPRACTIC REGISTRATION INFORMATION

1. PATIENT INFORMATION

Date_____

Name_____

Addrress_____

_____
City State Zip

Home Phone _____ Work_____

Sex ◻ M ◻ F Age_____ Birthdate_____

◻ Single ◻ Married ◻ Widowed
◻ Separated ◻ Divorced

In case of emergency, contact:_____
Name

_____ _____
Relationship Phone

_____
Address City State

Social Security #: _____-_____-_____

Driver's License #:_____

Occupation:_____

Employer:_____

Employer's Address:_____

Spouse's Name:_____

Spouse's Occupation:_____

Spouse's Employer:_____

Whom may we thank for referring you?_____

_____

2. INSURANCE

Person responsible for payment:_____

Relationship to patient:_____

Are you insured? ◻ Yes ◻ No

Health Insurance name:_____

Policy holder's name:_____

Birthdate:_____ SS #:_____

Policy #:_____

Group #:_____

Is the patient covered by additional insurance ? ◻ Yes ◻ No

Company name:_____

Policy Holder:_____

SS#:_____-_____-_____

ID / Group #:_____

3. ACCIDENT INFORMATION

Is your condition due to an accident? ◻ Y ◻ N

Type of accident: ◻ Auto ◻ Work ◻ Other

To whom have reported it to?

◻ Auto ins. ◻ Employer ◻ Other_____

Attorney (if applicable)_____

_____

4. PAYMENT IS EXPECTED AT THE TIME OF VISIT

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that the office of Dr. Bryce C. Hill will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Dr. Bryce C. Hill will be credited upon receipt, however, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment of my account in full. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered me will be immediately due and payable.

Patient's signature_____Date_____

Guardian's signature_____ Date_____