

DAPHNE CHIROPRACTIC CENTER, L.L.C.

REGISTRATION

Date _____

Chart Number: _____

Patient _____
Last Name First Name Initial

Home Phone _____ Work Phone _____ Cell Phone _____

Street Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Date of Birth _____ Race: _____

Married Single Widowed Separated Divorced Number of Children: _____
 Employed FT/PT Student FT Retired Male Female

Patient lives with Alone Spouse Children Other Parents Roomates Assisted Living

Social Security No. _____ - _____ - _____ Email Address: _____

Family Medical Doctor: _____

Would you like for us to provide your family medical physician with periodic written and/or oral reports of examination findings, treatment plans, and your progress under chiropractic care? yes no

Purpose of this Appointment: _____

Whom may we thank for referring you to us? _____

.....
EMERGENCY CONTACT:

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address: _____

City _____ State _____ Zip Code _____

YOUR EMPLOYER Company Name _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

Occupation _____ Full-time _____ Part-time _____

SPOUSE (PARENT) Name _____

Date of Birth _____ / _____ / _____ Social Security No. _____ / _____ / _____

Spouse Employer Name _____ Occupation _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

Please check any and all insurance coverage that may be applicable in this case.

Major Medical Worker's Compensation Medicaid Medicare Auto Accident Other

*****Please provide all applicable insurance cards so that a copy may be made.*****

I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office of any sum I now or hereafter owe this office by my attorney, out of proceeds of any settlement of my care and by any insurance company contractually obligated to make payment to me or you based upon the charges submitted for products and services rendered. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office 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 this office will be credited to my account upon receipt. However I clearly understand and agree that all services rendered to 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, all fees for products or professional services rendered will be immediately due and payable.

Patient's/Guardian's Signature _____ Date _____