

SYLVAN CHIROPRACTIC CLINIC, LLC

NEW PATIENT REGISTRATION—CONFIDENTIAL

Please answer all the questions completely. All information provided is strictly confidential. If you do not understand a question or are unsure of the information, please ask for assistance.

Name: _____ Date: _____

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

Date of Birth: ____/____/____ Age: _____ SS#: _____ - _____ - _____

Email: _____ Primary Phone: _____

Marital Status: M S W D Referred by: _____

Emergency Contact: _____ Relation: _____

Address: _____ Phone: _____

EMPLOYMENT INFORMATION

Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____

Spouse Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____

INSURANCE INFORMATION

Name of person responsible for payment: _____

Name of Insurance Co.: _____ Name of Insured: _____ ID# _____

Address: _____ Phone: _____

Is condition due to injury/illness arising from employment? Yes No

Date symptoms occurred or accident happened: _____

Have you lost any days from work? Yes No How many? _____ Date last worked? _____

MEDICAL INFORMATION

Date of last physical exam: _____ Are you pregnant? _____

Current primary care physician: _____

Address: _____ Phone: _____

What operations have you had? _____

Serious illnesses: _____

Ever been under Chiropractic Care? Yes No Dr.'s Name: _____

PAYMENT IS EXPECTED AT TIME OF VISIT

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and myself. I give this office power of attorney to endorse checks made out to me, to be credited to my account. I authorize the physician to release any information that is required or necessary for my claim. I clearly understand and agree that all services rendered to me are charged directly to me and will be immediately due and payable. I understand that I am directly and fully responsible to Sylvan Chiropractic Clinic, LLC for services rendered and that this agreement is solely made for the protection of Sylvan Chiropractic Clinic, LLC. Should collection procedures become necessary to collect the amount due Sylvan Chiropractic Clinic, LLC for my treatment, additional charges for attorneys' fees and interest will be added to the balance owed for treatment. I further understand that such payment is not contingent on any settlement, insurance payment, including the balance remaining after payment of possible insurance benefits, judgment, or verdict by which I may eventually recover said chiropractic services.

(Please continue to opposite side!)

SYLVAN CHIROPRACTIC CLINIC, LLC

ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

- 1. _____ I hereby authorize Sylvan Chiropractic Clinic, LLC to provide chiropractic services for me. I have also received a Notice of Privacy Practices, if requested.
- 2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Sylvan Chiropractic Clinic, LLC.
- 3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorneys' fees and cost of collections.
- 4. _____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Sylvan Chiropractic Clinic, LLC (5440 SW Westgate Drive, Suite 245, Portland, OR 97221).
- 5. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

Dated this _____ day of _____ 20_____.

Patient Signature

Guarantor's Signature

Guarantor's Relationship to Patient

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian I hereby authorize treatment for the following:

Patient's full name

DOB _____

to any chiropractic treatment deemed advisable , if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _____ and expires _____.

Parent/Guardian Signature: _____ Witnessed by: _____