

NEW PATIENT REGISTRATION

Today's Date _____

Name _____ Acct# _____ Int _____
Last First Middle

(Complete Mailing)

Address _____ **
Street Apt# City State Zip

Social Security # _____ - _____ - _____ Date of Birth _____

Home Phone # (_____) _____ - _____ ** Work Phone # (_____) _____ - _____ **

Cell Phone # (_____) _____ - _____ ** E-mail Address: _____ **

Emergency Contact _____ Relationship _____ Phone# (_____) _____ - _____

Employer _____ Occupation _____ Phone# (_____) _____ - _____

Is this visit routine/accident/illness/other: _____ If Accident (date) _____

RESPONSIBLE PARTY INFORMATION

Name (Guarantor) _____
Last First Middle

Relationship to Patient _____

Address _____ Phone# (_____) _____ - _____
Street City State Zip

Employer _____

Address _____ Phone # (_____) _____ - _____

Name of Insurance _____ ID# _____ Grp# _____

(please complete other side)

Please notify our front office staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

I have read and understand that this alternative is available to me _____
Signature Date

King Chiropractic Clinic, S.E. 15348 SE Division, Portland, OR 97236
ACKNOWLEDGEMENT AND UNDERSTANDING
Phone: 503-761-9076 • Fax: 503-761-9679 • www.kingchiroclinic.com

Please initial each item below.

- 1. _____ I hereby authorize King Chiropractic Clinic to provide Chiropractic Services for me.
- 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 King Chiropractic Clinic.
- 3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's 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 King Chiropractic Clinic, 15348 SE Division St. Portland, OR 97236
- 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 Signature **Relationship to Patient**

AUTHORIZATION TO TREAT A MINOR

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

_____ DOB _____
Patient's full name

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 _____.

Signature _____ Witnessed by _____
(Parent or Guardian)