

REGISTRATION

Date _____ Home Phone _____ Work Phone _____ Email _____

Patient _____
 Last Name _____ First Name _____ Initial _____

Street Address _____

City _____ State _____ Zip _____

Sex M F Age _____ Birth date _____ Single Married Widowed Separated Divorced

Social Security # _____ Driver's License # _____

Insured Name _____ How and where did you learn about this clinic? _____
 Last Name _____ First Name _____ Initial _____

Relationship To Insured Self Spouse Child Other

Condition/Illness Related To Illness Employment Auto Other

EMPLOYER	Company Name _____ Occupation _____ Address _____ Phone _____ <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time City _____ State _____ Zip _____
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SPOUSE (PARENT)	Name _____ Last Name _____ First Name _____ Initial _____ Birthdate _____ Social Security # _____ Employer Name _____ Occupation _____ Address _____ Phone _____ City _____ State _____ Zip _____
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PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have. Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID#: _____
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SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have. Insurance Company or Health Care Plan Name _____ Policy/Group #: _____ Effective Date: _____ Name of Insured: _____ ID#: _____
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MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury <u>someone else might be legally liable for</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No Your initials: _____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No Family Physician _____ Person to contact in emergency (Name and Phone #) _____ Attorney _____ Telephone _____ Address _____
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PATIENT AGREEMENT	<p>LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS</p> <p>In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to <u>Advanced Chiropractic Wellness Center</u> all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.</p> <p>I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.</p> <p>This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.</p> <p>_____ Signature of Insured / Guardian</p> <p>_____ Date</p>
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