

ARMSTRONG CHIROPRACTIC AND REHABILITATION

WELCOME! Our goal is to help you achieve the best health possible. Please provide the following information as completely as you can. The better we communicate, the better we can care for your needs.

Patient Registration

Patient Name		How do you wish to be addressed?	Date of Birth	
Address		City	State	Zip
Home Phone #	Social Security #		Driver's License #	
Email Address	Patient Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other		School Status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> N/A	

Account Information

<input type="checkbox"/> Patient's Name <input type="checkbox"/> Guardian's Name	Employer	Work Phone #
<input type="checkbox"/> Spouse's Name <input type="checkbox"/> Guardian's Name	Employer	Work Phone #
If the patient is a child, who is responsible for this account?		
Is the condition we are treating related to a: <input type="checkbox"/> auto accident <input type="checkbox"/> work accident <input type="checkbox"/> other accident <input type="checkbox"/> N/A		

PLEASE FILL OUT YOUR HEALTH INSURANCE INFORMATION BELOW. IF YOUR VISIT IS RELATED TO AN ACCIDENT, PLEASE PUT YOUR ACCIDENT INSURANCE INFORMATION ON THE ACCIDENTAL INJURY FORM.

Primary Health Insurance Information

Primary Insurance Company	Identification #	Name of Policyholder	
Policyholder's Social Security #	Policy/Group #	Policyholder's Date of Birth	Insurance Phone #

Secondary Health Insurance Information

Secondary Insurance Company	Identification #	Name of Policyholder	
Policyholder's Social Security #	Policy/Group #	Policyholder's Date of Birth	Insurance Phone #

How did you learn about our office? (If from a friend or relative, his/her name.)	Someone not living with you to contact in case of emergency (name and phone #).
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Other family members in this practice:

Family Medical Doctor:	When doctors work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process my insurance claim. I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I hereby authorize the doctor to examine me and treat my condition as he or she deems appropriate through the use of chiropractic health care and I give authority for these procedures to be performed. The doctor will not be held accountable for any pre-medically diagnosed conditions nor for any medical diagnosis.

Signature: _____ Date: _____