

## Patient Registration Document

### **Patient Information** (please print clearly)

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email Address: \_\_\_\_\_

SSN #: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: **M** **F**

Marital Status: **Single Married Widowed Divorced** Number of Children: \_\_\_\_\_

Previous Chiropractic Treatment: **Y N** Referred by: **Ins Web Sign Friend:** \_\_\_\_\_ **Other:** \_\_\_\_\_

### **Work Information** (please print clearly)

Employer's Name: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

### **Spouse Information** (please print clearly)

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN#: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

### **In case of Emergency** (please print clearly)

Contact Person: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ Relation: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**I understand and agree to authorize the doctors or staffs to administer examination procedures and treatments, as deemed necessary:**

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Consent to treat a minor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Guardian or Spouse's Signature of Authorizing Care:** \_\_\_\_\_ **Date:** \_\_\_\_\_