BRONSTON CHIROPRACTIC PATIENT REGISTRATION FORM

DATE_____ *NEW* ☐ *UPDATE* ☐

PATIENT NAME _____ _____ _____
LAST FIRST M.I.

BIRTHDATE _____ SOCIAL SECURITY _____

(IF UNDER 18, COMPLETE RESPONSIBLE PARTY INFORMATION)

SEX: MALE FEMALE MARITAL STATUS: S M D W OTH

ADDRESS _____TELEPHONE_____

CITY _____STATE_____ZIP_____

EMAIL ADDRESS:_____CELL PHONE_____

EMPLOYER NAME _____ TELEPHONE _____

ADDRESS _____

EMAIL ADDRESS:_____

***For anyone under the age of 18 – parent / guardian must complete this area before treatment of a minor:**

RESPONSIBLE PARTY NAME_____

ADDRESS _____TELEPHONE _____

CITY _____STATE _____ ZIP_____

EMPLOYER NAME _____ TELEPHONE_____

ADDRESS _____CITY_____STATE_____ZIP_____

SOCIAL SECURITY NUMBER _____DATE OF BIRTH _____

_____ _____

Signature of parent / guardian **Date**

NEAREST RELATIVE **NOT** LIVING WITH YOU:_____
PHONE NUMBER:_____ RELATIONSHIP:_____

WHAT MADE YOU CHOOSE BRONSTON CLINIC? (circle one)

ANOTHER PATIENT ANOTHER CHIROPRACTOR ATHLETIC TRAINER BILLBOARD MEDICAL DOCTOR REPUTATION
LOCATION YOU ARE A RETURNING FORMER PATIENT WORD OF MOUTH TELEVISION COMMERCIAL
RADIO COMMERCIAL NEWSPAPER (PLEASE SPECIFY)_____
YELLOW PAGES EMPLOYEE OTHER_____

PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD(s): **If insured is other than patient – we need insured's FULL NAME_____ Date of Birth_____ Employer's Name _____**

I AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO: *BRONSTON CHIROPRACTIC CLINIC*. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR MY ENTIRE ACCOUNT BALANCE AND THAT IT IS THE POLICY OF BRONSTON CHIROPRACTIC TO BILL MY INSURANCE CARRIER AS COURTESY TO ME. SHOULD MY INSURANCE CARRIER NOT REMIT PAYMENT WITHIN 30 DAYS I WILL BE EXPECTED TO PAY MY ACCOUNT BALANCE. The contract is between my insurance carrier and myself and I understand that I may have to follow-up with my insurance carrier regarding unpaid claims. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR MY COPAY, DEDUCTIBLE AND COINSURANCE AT THE TIME OF SERVICE.
***This authorization is in effect until I choose to revoke it.**

_____ _____

Signature (parent/guardian if patient is under 18) **Date**