PATIENT REGISTRATION

(INFORMATION REQUIRED FOR CASE HISTORY FILE)

☐ SINGLE
☐ MARRIED
☐ WIDOWED
☐ DIVORCED
☐ SEPARATED

Patient's Name _____ Age _____ Date of Birth _____
(PLEASE PRINT FULL NAME) (MO. DAY YEAR)

Address _____ Phone _____
STREET NO. & NAME CITY STATE ZIP YOURS OR NEAREST

Soc. Sec. # _____ Driver's Lic. # _____ Responsible Party _____
FULL NAME OF PERSON TO PAY

Cell Phone: _____ Email: _____

Employer _____ Occupation or Profession _____
(OF PATIENT OR HUSBAND, WIFE, ETC.)

Employer's Address _____ Phone _____
STREET NO. CITY STATE

Nearest Relative _____ Address _____
RELATIONSHIP AND FULL NAME

This visit is the result of an: ☐ Auto Accident ☐ Injury ☐ Accident on the job ☐ Other _____

Do you have medical or health insurance? ☐ Yes ☐ No ☐ What company? _____

☐ Union _____ ☐ Worker's Comp. _____
NAME NAME OF COMPANY

Complaint: _____ Have you had X-Rays before? ☐ Yes ☐ No When? _____

_____ What areas were X-Rayed? _____

Female: Are you now pregnant? ☐ Yes ☐ No
How long? _____

Referred by _____

PLEASE NOTE: This office will gladly prepare insurance forms and reports; however, we cannot render services on the assumption that our charges will be paid by an insurance company. All professional services are charged directly to the patient, therefore basic responsibility for payment is yours.

Date _____ Signature _____