



Prime Health

Family & Sports Chiropractic Wellness Center



New Patient Registration

Name _____ Date _____

Patient's Clinic ID # _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone(_____) _____ Sex M F Age _____ Date of Birth _____

Single Married Widowed Separated Divorced

Occupation _____ Shift 1 2 3 Job Description _____

Employer _____ Employer Phone(_____) _____

Address _____

Years Worked _____ Spouse's Name _____ Children/Ages _____

Spouse's Occupation _____ Spouse's Employer _____

Spouse's Insurance Carrier _____ Who referred you? _____

Name of Last Chiropractor _____ Name of Primary Physician _____

FOR OFFICE USE ONLY

Accident Information

Pain Due to Injury? Yes No Accident Due to: Auto Collision Personal Injury Work Report Made? Yes No

Attorney Name _____ Attorney Phone(_____) _____ Accident Claim # _____

Protected Information

Work Phone(_____) _____ Ext. _____ Cell Phone(_____) _____

E-mail _____ Best Time to Call _____

1) Emergency Contact _____ Relationship _____ Home Phone(_____) _____

Work Phone(_____) _____ Cell Phone(_____) _____

Address _____

2) Emergency Contact _____ Relationship _____ Home Phone(_____) _____

Work Phone(_____) _____ Cell Phone(_____) _____

Address _____

Major Complaints/Pain Regions

How Long in Pain? _____ Regions: Neck Low Back Arms Mid Back Hips Legs

Pain Worse in: morning evening

Insurance Information

Who is responsible for this account? _____ Relationship to Patient _____

Insurance Carrier _____ Policy Number _____

Is there other insurance? Yes No Subscriber Name _____ Subscriber Social Security # _____

Subscriber Date of Birth _____ Group Number _____

Mastercard _____ Exp: _____ Visa _____ Exp: _____

Checking Account Number _____

Authorization/Assignment

Patient Signature _____ Date _____ Parent/Guardian Signature _____ Date _____

**Chiropractic Authorization Release & Explanation
Holding Fee Form**

I, _____ hereby understand that the fee of _____ that I am presently paying PRIME HEALTH is a partial payment until such time that my insurance company acknowledges this claim and pays PRIME HEALTH directly in full, all monies due for services rendered on my behalf.

Patient signature or authorized person acting on patient's behalf *Date*

Patient's or Authorized Person's Signature

A. I authorize release of any medical information necessary to process this claim and request payment of insurance benefits either to myself or to the party who accepts assignment below.

Patient signature or authorized person acting on patient's behalf *Date*

B. I authorize payment of any medical benefits from _____ to be paid directly to PRIME HEALTH for any services rendered to me.

Patient signature or authorized person acting on patient's behalf *Date*

Authorization and Assignment

In consideration of you providing care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I authorize the direct payment to you of any sum I now or hereafter owe you by my attorney, out of the proceeds of any settlement of my case, and by any insurance company obligated to make payments to me or you based in whole, or in part, upon the charges made for your services.
3. In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle or otherwise resolve said claim as you see fit. It is understood, however, that until all reasonable efforts have been made to collect the sums due from the insurance company or companies contractually obligated, you will refrain from attempts and efforts to collect the amounts owed directly from me. I understand that whatever amounts you do not collect from insurance companies' proceeds, whether it be all or part of what is due, I personally owe you.
4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this state/province of _____.
5. I further agree that this Authorization and Assignment is irrevocable until all monies owed PRIME HEALTH, are paid in full.

Patient signature or authorized person acting on patient's behalf *Date*

Staff Signature *Date*

Records Release

To _____, I hereby authorize you to release to _____ any information including the diagnosis and records of any examination or treatment rendered to me during the period between _____ and _____.

Patient signature or authorized person acting on patient's behalf *Date*

Staff Signature *Date*