

Back-2-Back Chiropractic, P.C.

3000 NW Stucki Place, Suite 180

Hillsboro, OR 97124

T (503) 726-2225 F (503) 726-2224

Patient Registration Form

*Confidential Data***PERSONAL INFORMATION**

| | | | |
|--|--|------------------------------------|---------------|
| Mr. / Mrs. / Miss / Dr. | | / / / | |
| Patient Name (first, middle initial, last) | | Patient DOB (m/d/y) Age | |
| Patient Address | | City State Zip | |
| Home Phone | Work Phone | Cell Phone | Email Address |
| Social Security # | | Drivers License (State, Number) | |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Other | | |
| Your Occupation | | Your Employer | |
| Referred by: | Name: _____ | | |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Family Member | <input type="checkbox"/> Physician | |
| <input type="checkbox"/> Website | <input type="checkbox"/> Advertisement | <input type="checkbox"/> Other: | _____ |
| Payment for Services will be by: <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <input type="checkbox"/> Health Insurance <input type="checkbox"/> Automobile Insurance <input type="checkbox"/> Workers Compensation | | | |

INSURANCE INFORMATION

| | | | |
|--|---------|-----------------------------|-----------------------|
| Name of Insurance Co. | | Insurance Co. Phone Number: | |
| Insurance Co. Address | | City State Zip | |
| Insurance Co. Policy # | Group # | Plan # | Policy Effective Date |
| Insured's Employer | | Insured's Employer Address | |
| Are you covered by more than one insurance company? <input type="checkbox"/> No <input type="checkbox"/> Yes Name: _____ | | | |

PRIMARY CARE PHYSICIAN

| | | | | |
|-------------------|--|------------------|--|-----------|
| Name of Physician | | Name of Practice | | Tel |
| Practice Address | | City | | State Zip |

IN CASE OF EMERGENCY

| | | | |
|----------------------------|-------------------------|------------|------------|
| Name of Relative or Friend | Relationship to Patient | Home Phone | Cell Phone |
|----------------------------|-------------------------|------------|------------|

The above information is true to the best of my knowledge. I authorize Back-2-Back Chiropractic to contact my insurance company as necessary and all benefits to be paid directly to Back-2-Back Chiropractic. I understand that I am responsible for any balance. I also authorize Back-2-Back Chiropractic or my insurance company to release any information required to process my claim.

Patient Signature (guardian if under 18)

Date