PORTLAND
CHIROPRACTIC · NEUROLOGY

Patient Registration

Please provide us with the following information. Should you have any questions or require assistance a member of our staff would be happy to help.

Clinic ID: Date:

Patient Contact Information

Last Name | First Name | M.I. | Prefer to be called

Street Address | City | State | Zip

Home Phone | Mobile Phone

Work Phone | Email

Patient Personal Information

Date of Birth | Sex | Social Security #

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Spouse or Guardian

Name | Relationship to Patient (spouse/guardian)

Home Phone | Mobile Phone | Work Phone

Employer Name

Emergency Contact

Name | Relationship to Patient

Home Phone | Mobile Phone | Work Phone

Patient Employment Information

Employer Name | Occupation

Street Address | City | State | Zip

How did you hear about our clinic?

☐ Radio/TV Ad
☐ Social Media
☐ Referral from another patient — Please specify: _____
☐ Referral from another provider — Please specify: _____
☐ Other: _____

PORTLAND
CHIROPRACTIC · NEUROLOGY

Patient Account Information

Please provide the following information. Should you have any questions or require assistance a member of our staff would be happy to help.

Clinic ID: Date:

Patient Information

Last Name First Name M.I. Prefer to be called

Age Date of Birth Social Security # Sex

Are you here because you were involved in a motor vehicle collision?	☐ yes	☐ no
Are you here because you were injured at your place of employment?	☐ yes	☐ no
Are you here because you were involved in another type of accident?	☐ yes	☐ no
Will you be using health insurance to supplement payment to our office?	☐ yes	☐ no

*If Yes to above, please complete the following two sections of this form

Primary Insurance Coverage

Primary Insurance Company Policy ID # Group #

Policy Holder's Name (if different from patient) Birth Date Relationship to Patient

Secondary Insurance Coverage

Secondary Insurance Company Policy ID # Group #

Policy Holder's name (if different from patient) Birth Date Relationship to Patient

Disclosure

We are here to provide services to our patients the best way we know how. We understand the value of heath insurance to our patients. However, because health insurance plans are intended only to supplement out of pocket expenses for your care, your insurance may not cover all the care you need. Our staff will verify your insurance benefits individually and report this supplemental coverage to you.

Our relationship is with each patient individually and not with the insurance companies. Therefore, following your initial examination, should we determine that you are a candidate for treatment in our office, we will recommend a treatment plan that is designed specifically for you. It is our intention to be able to provide care for our patients that is affordable regardless of health insurance coverage.

I understand and agree to the following:

- There is no guarantee that my health insurance plan or policy will pay for all or part of my care
- I will be informed of fees and charges by the staff before these services are performed
- As the patient or guardian of the patient, I am ultimately responsible for all charges incurred during services rendered as a result of care in this office
- A thorough health history, clinical examination, and pertinent diagnostic testing will be performed today by the doctor to evaluate my case and I am requesting these services

Signature of patient or guardian Date