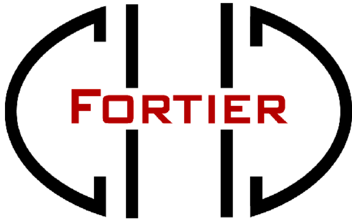

FORTIER CHIROPRACTIC HEALTH CARE

"Life Without Limits"

Dr. Seth A. Fortier ▪ 220 Ellsworth St. SW ▪ Albany, OR 97321▪ Ph.(541)926-0510 ▪ Fax(541)926-5540

CONFIDENTIAL NEW PATIENT REGISTRATION

Thank you for choosing our practice for your health care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help!

Today's Date _______________

Name____ **SSN** ______________
Last First Middle Init.

Address____
Street Apt# City State Zip

Marital Status: M / W / S / D / Sep. **DOB**___/___/______ **Age** ______ **Sex** M/F

Phone H (_____) ______–_______ **W** (_____) ______–________ **C** (_____) ______-_________

E-mail Address: ____________________________ **Employer/Occupation** ___________________

Emergency Contact_________________ **Relationship**____________ **Phone#** (_____)______–_______

Is this visit routine/accident/illness/other: __________________ **If Accident (date)** __________

Whom may we thank for referring you to us? ____

RESPONSIBLE PARTY INFORMATION

Name (Guarantor)____
Last First Middle

Relationship to Patient _____________________________

Address ____ **Phone#** (_____)______–_______
Street City State Zip

Employer/Occupation _____________________________

Address____ **Phone #**(_____)______–_______

**Please notify our front office staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

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ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

1. ______ I hereby authorize Fortier Chiropractic Health Care to provide Chiropractic Services for me.

2. ______ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Fortier Chiropractic Health Care.

3. ______ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. ______ I hereby assign all Chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Fortier Chiropractic Health Care 220 SW Ellsworth St. Albany, Or 97321

5. ______ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

Dated this _________day of _______________ 20_____.

____

Patient Signature

____

Guarantor Signature **Relationship to Patient**

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

____ DOB ______________________

Patient's full name

to any chiropractic treatment deemed advisable , if a parent or legal guardian is not available when the child is brought in for treatment. This authorization will be effective as of _______________

Signature______________________________________

(Parent or Guardian)