

New Patient Registration

Patient ID Label

General Information			
Name _____			
Street Address _____			
Zip _____	City _____	State _____	
Birthdate ____/____/____	Age _____	Social Security # _____-____-_____	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Marital <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced			
How did you hear about our office?			
<input type="checkbox"/> From one of our patients? Name _____			
<input type="checkbox"/> From a physician or health care practitioner? Name _____			
<input type="checkbox"/> From other source? Please Specify _____			
Phone (home) _____-____-_____		Phone (Work) _____-____-_____	
Phone (other) _____-____-_____		Email _____	

Insurance Information			
Do you have insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Policy Holder? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent			
Insurance Carrier 1 _____		Plan Name _____	
Insurance Carrier 2 _____		Plan Name _____	
Insurance Carrier 3 _____		Plan Name _____	
Employer (of policy holder) _____			
Address _____		Zip _____	City _____ State _____

Privacy Policy at Meridian Chiropractic Center

I acknowledge that the Notice of Privacy Practices (the Notice) for Meridian Chiropractic Center (the Center) has been provided to me. The Notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the Center. The Notice is also provided on request at the administration desk of the Center. This Notice also describes my rights and the Center's duties with respect to my protected health information.

The Center reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I hereby authorize the Center staff to use my name, address, telephone number, email address and clinical records to contact me with appointment reminders, birthday, holiday, or sympathy cards, newsletters, or other health-related or clinic policy information. If contact is made by telephone, a message may be left on my answering machine.

I understand I have the right to refuse to give this authorization. I have been assured that such refusal will not affect the treatment provided or methods used for reimbursement of care.

This notice is effective April 1, 2003 and expires seven years after my last date of service at the Center.

Patient Signature _____ **Date** ____/____/____

Consent for Care

I hereby authorize Meridian Chiropractic Center and its doctor(s) to administer care as they deem necessary to me:

Patient Signature _____ **Date** ____/____/____

Consent for Care of a Minor

I hereby authorize Meridian Chiropractic Center and its doctor(s) to administer care as they deem necessary to my minor child:

Parent/Guardian Name _____ **Relationship to Patient** _____

Parent/Guardian Signature _____ **Date** ____/____/____