

GARDINER FAMILY CHIROPRACTIC  
NEW PATIENT REGISTRATION FORM

**PATIENT INFORMATION**

Full Name: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Name you prefer to be called: \_\_\_\_\_ Email: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*Please check the box next to the phone number where you would prefer to be contacted.*

Home Phone# \_\_\_\_\_  Cell Phone#: \_\_\_\_\_

Work Phone#: \_\_\_\_\_ ext. \_\_\_\_\_ Ok to leave a message at work? Y / N

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Clinic Name: \_\_\_\_\_ Location: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Phone#: \_\_\_\_\_

Who referred you to our office?: \_\_\_\_\_

**FAMILY INFORMATION**

Marital Status: M S O

Spouse/Significant Other: \_\_\_\_\_

Dependants: (Minors list siblings) \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**MEDICARE AUTHORIZATION:**

I have been advised that Medicare may deny any treatment that I receive over the allotted number of visits allowed for my condition. Although Medicare may reduce or deny the procedure(s), I have advised the doctor to proceed with the service(s) and I will assume full responsibility for payment.

If you have utilized your covered visits at another chiropractic facility, Medicare may deny any additional visits for your condition, even though you are seeing another doctor.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

**WERE YOU AWARE THAT?**

Doctors of Chiropractic work with the nervous system? Y / N

The nervous system controls all bodily functions and systems? Y / N

Chiropractic is the largest natural healing profession in the world? Y / N

If Chiropractic care starts at birth, you can achieve a higher level of health throughout life? Y / N

**INSURANCE RELEASE /  
PAYMENT FOR SERVICES:**

I authorize the release of medical information to process insurance claims. I also authorize assignment of benefits and agree to pay any balance due, not covered by my insurance, to the doctors for the services rendered.

Signature of Patient or Parent/Guardian

\_\_\_\_\_

Date: \_\_\_\_\_