



585-223-2610

Patient Registration Information

Please print & complete **ALL** sections:

Is your condition a result of a work Injury? Yes or No

Is your condition a result of an auto accident? Yes or No

Marital status: Single Married Divorced Widowed Sex: Male or Female

Name: _____	SS#: _____	DOB: _____
Street address: _____		
City: _____	State: _____	Zip code: _____
Home phone: _____	Work phone: _____	
Cell phone: _____	E-mail: _____	

Employer: _____	Occupation: _____	

Insurance carrier: _____ Insurance ID # _____

Group # _____

Who referred you to our office? _____

Have you ever been to a chiropractor before? Yes or No

If YES, when and what for? _____

Reason for today's visit: _____

When did you first notice this problem? _____

Did this condition ever occur before? Yes or No If YES, when? _____

Other physicians treating you for this condition: _____

List all Medications: _____

Please list all previous surgeries, trauma or fractures: _____

Past medical history/family medical history: _____

Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Date of last visit: _____

Emergency Contact: _____

Home phone: _____ Work phone: _____

Cellular phone: _____ Relationship: _____

Please read & sign BOTH statements below:

Patient's Signature:

I authorize the release of any medical or other information necessary to process claims regarding medical treatment rendered at Perinton Hills Chiropractic, PC. I also authorize payment of medical benefits to the rendering clinician at Perinton Hills Chiropractic, PC.

Name: _____ Date: _____

Insured's Signature (if different than patient):

Name: _____ Date: _____