

NEW PATIENT REGISTRATION FORM

PLEASE FILL OUT THIS FORM COMPLETELY.
ALL INFORMATION IS STRICTLY CONFIDENTIAL.

NAME: _____ TODAY'S DATE: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: () _____ ALTERNATE PHONE NUMBER: () _____

DATE OF BIRTH: _____ EMAIL ADDRESS: _____

SEX: M F MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW SEPARATED

ARE YOU A STUDENT: FT PT ARE YOU EMPLOYED: FT PT NOT EMPLOYED

EMPLOYER: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE: () _____

INSURANCE INFORMATION:

DO YOU HAVE HEALTH INSURANCE: NO YES, IF YES, INSURANCE COMPANY: _____

ID#: _____ GROUP #: _____

DO YOU HAVE A MEDICARE POLICY: NO YES IF YES, ID#: _____

IF YOU HAVE MEDICARE, DO YOU HAVE A SECONDARY OR A SUPPLEMENTAL POLICY: NO YES

ADDITIONAL INSURANCE CO: _____ ID #: _____

***IF YOUR INJURY IS DUE TO AN AUTOMOBILE ACCIDENT, A WORKER'S COMPENSATION INJURY, OR
A THIRD PARTY IS RESPONSIBLE FOR COVERAGE, PLEASE FILL OUT THIS SECTION:***

IS YOUR CONDITION RELATED TO AN AUTOMOBILE ACCIDENT: NO YES IN WHAT STATE: _____

IS YOUR CONDITION RELATED TO YOUR EMPLOYMENT: NO YES

IS A THIRD PARTY RESPONSIBLE FOR YOUR COVERAGE: NO YES

I understand and agree, regardless of any insurance policies I may qualify for, I am ultimately responsible for the entire balance on this account for professional services rendered. I hereby authorize the Doctor(s) to release any medical or other information necessary to process any and all claims and to secure the payment of benefits. I also request payment of government or medical benefits to Miano Family Chiropractic Center, LLC. I authorize the use of this signature on all insurance submissions.

SIGNATURE

NAME OF PARENT / GUARDIAN (IF MINOR)

TODAY'S DATE

ADDITIONAL INFORMATION

PATIENT NAME: _____ BIRTH DATE: _____

ACKNOWLEDGMENT OF HIPAA

I received and had the opportunity to review the Notice of Privacy Practices on the date below on behalf of Miano Family Chiropractic Center, LLC. I understand that the Notice describes the uses and disclosures of my protected health information by Miano Family Chiropractic Center, LLC, and informs me of my rights with respect to my protected health information.

PATIENT / LEGAL REPRESENTATIVE SIGNATURE

TODAY'S DATE

PATIENT / LEGAL REPRESENTATIVE PRINTED NAME

IF LEGAL REPRESENTATIVE, INDICATE RELATIONSHIP

CONSENT TO CONTACT VIA PHONE & EMAIL:

IF I DO NOT ANSWER MY PHONE:

LEAVE A DETAILED MESSAGE LEAVE MESSAGE ASKING FOR A RETURN CALL DO NOT LEAVE A MESSAGE

I GIVE PERMISSION TO CONTACT ME VIA TEXT FOR THE PURPOSE(S) OF:

APPOINTMENT REMINDERS MOVE AND/OR CANCEL AN APPOINTMENT DO NOT TEXT MY CELL PHONE

I GIVE PERMISSION TO USE MY EMAIL FOR:

OFFICE ANNOUNCEMENTS MONTHLY NEWSLETTERS APPOINTMENT REMINDERS DO NOT USE MY EMAIL

CONSENT TO PUBLICLY SHARE PHOTOS / VIDEOS / WRITTEN CONTENT

I grant permission to Miano Family Chiropractic Center, LLC to use written, photo, and/or video content I have volunteered for marketing and/or educational purposes including, but not limited to: website posting printed materials, office display, and/or social media outlets. If I no longer grant MFCC, LLC permission to use my content, I will notify MFCC, LLC in writing.

PATIENT / GUARDIAN SIGNATURE: _____

_____ I give consent for myself (& the above listed minor) to be tagged on social media.

_____ I do not give consent for myself (& the above listed minor) to be tagged on social media.

CONSENT TO TREAT A MINOR

I hereby authorize the physician(s) of the Miano Family Chiropractic Center, LLC to administer treatment as deemed necessary to the above listed minor.

PARENT / GUARDIAN PRINTED NAME: _____

PARENT / GUARDIAN SIGNATURE: _____

Staff Witness: _____ Date: _____