Miano Family
Chiropractic Center, LLC

DR. JENNIFER L. MIANO
CHIROPRACTIC PHYSICIAN

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NEW PATIENT REGISTRATION FORM

Please fill out this form completely.
All information is strictly confidential.

NAME: _____ DATE: _____

HOME ADDRESS: _____

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: ( ) _____

IS YOUR CONDITION RELATED TO:

YOUR EMPLOYMENT: ◊ NO ◊ YES IF YES, IN WHAT STATE: _____

AN AUTOMOBILE ACCIDENT: ◊ NO ◊ YES IF YES, IN WHAT STATE: _____

ANOTHER ACCIDENT: ◊ NO ◊ YES IF YES, PLEASE DESCRIBE: _____

ARE YOU COVERED BY MEDICARE: ◊ NO ◊ YES IF YES, ID#: _____

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

INSURANCE CO: _____ ID #: _____

IF THIS INJURY IS DUE TO AN AUTOMOBILE ACCIDENT, OR A WORKER'S COMPENSATION INJURY, PLEASE ADVISE THE FRONT DESK.

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: _____