WELCOME

FLOWERS CHIROPRACTIC
REGISTRATION/ HISTORY

PATIENT INFORMATION

Date _____

Patient Legal Name _____

Prefer to be called _____

Address _____

City/ St / Zip _____

Email _____

Home Phone ( ) _____

Cell Phone ( ) _____

May we send you text updates? ☐ YES ☐ NO

Cellular Carrier _____

Gender ☐ M ☐ F Date of Birth _____

Marital Status ☐ Married Spouse _____

☐ Separated ☐ Divorced ☐ Partnered

☐ Widowed ☐ Single ☐ Minor

Social Sec # _____

Drivers Licence # _____

Drivers Licence State _____

Occupation / Job Title _____

Patient Employer or School _____

Employer or School Phone _____

Employer or School Address _____

_____

Emergency Contact Name _____

Relationship _____

Emergency Contact Phone _____

Referred by _____

MOTOR VEHICLE COLLISION INFO

I was ☐ the Driver ☐ a Passenger

The vehicle I was riding in is owned by:

☐ Myself ☐ Other: _____

(i.e. person, rental agency, employer)

The vehicle I was riding in

☐ does NOT have auto insurance

☐ is insured (if insured, list insurance co name)

Auto Insurance Company_____

Policy Holder Name _____

☐ I have NOT reported injuries to above insurance co

☐ I have filed a claim and reported I was injured

Claim Number _____

Adjuster Name & No _____

☐ I have NOT received medical care since accident

☐ I have received medical care since accident

List doctor or medical facility: _____

ACCIDENT INFORMATION

Condition is due to: ☐ Auto Accident ☐ Personal Injury

☐ Work Injury ☐ Other _____

Date of Accident / Injury _____

To whom have you reported your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other

☐ Attorney Name (If applicable) _____

Attorney Phone # _____

☐ Yes, I have signed a lien

PERSONAL INSURANCE INFORMATION

Policy Holder _____

Relationship to patient _____

Patient Health Ins Co _____

Ins Co Phone # _____

Group # _____ Policy # _____

Ins Co Phone # _____

WORK ACCIDENT INFO

Employer Name at time of injury _____

Employer Phone _____

Occupation at time of injury _____

☐ FT ☐ PT Last date worked _____

Workers Compensation Insurer _____

Workers Comp Ins Phone _____

Claim Number _____

☐ I have NOT received medical care since the accident / injury

☐ I have received medical care

List doctor or medical facility: _____

Acknowledgement & Agreement

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand that Pain syndromes can be caused by conditions (such as tumors, etc) which may be visualized by x-rays. Should doctor deem x-rays are not necessary for my condition, I agree not to hold anyone associated with this clinic responsible for such pathology.

I authorize the relaease of any medical information necessary to process this claim. I also request payment of my health and/or government benefits be directed to: **Dr. Billy R. Flowers** who accepts assignment when insurance pays directly.

I agree all claims submitted by this office are my responsibility to settle regardless of my insurance company. The information I have completed is accurate and true to my knowledge.

_____ _____

Patient / Guarantor Signature Date