|  |  |  |  |
| --- | --- | --- | --- |
| **Demographics:** | Patient |  | Guarantor/Emergency Contact |
| First Name / M.I. |  |  |  |
| Last Name |  |  |  |
| Street Address |  |  |  |
| City / Zip |  |  |  |
| Social Security # |  |  |  |
| Gender |  |  |  |
| Date of Birth |  |  |  |
| Home Phone |  |  |  |
| Work Phone |  |  |  |
| Cell Phone |  |  |  |
| Cell Carrier |  |  |  |
| Email |  |  |  |
| Preferred Method of Contact |  |  |  |
| Marital Status |  |  | Relation to Patient: |
| Spouse First Name |  |  | Insurance Payor: |
| Race |  |  | Group #: |
| Ethnicity |  |  | Policy #: |
| Primary Language |  |  | □ Worker’s Comp □ Auto □ Personal Injury |
|  |  |  |  |

|  |  |
| --- | --- |
| Family Doctor: | Phone: |
| Other Doctor: | Phone: |
| Other Doctor: | Phone: |

|  |  |
| --- | --- |
| Current Employer: | Position: |

|  |
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| Please initial each line after reading: |
|  | My signature below indicates that I read the Informed Consent Policy of Reynolds Chiropractic and understand the information, risks and benefits of treatment. |
|  | My signature below indicates I have read and understand the Payment Policy of Reynolds Chiropractic and that I accept full responsibility for all services rendered. |
|  | My signature below indicates I have read and understand the Notice of Privacy Practices and Patient Rights Form and that I acknowledge my rights. |
|  | My signature below indicates that I understand I may request a copy of these policies or my medical records, at any time for my own personal records. |
|  | By signing below, I attest that all information I provide to the doctor and staff is truthful and accurate, and that I answer all questions to the best of my ability. |
|  |  |
| Patient Signature / Guardian Signature (if patient is under 18) | Today’s Date |