|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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: |

|  |  |  |
| --- | --- | --- |
| 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 |