

PURELIFE PATIENT REGISTRATION FORM

PATIENT INFORMATION		Date:
Name _____	Social Security No. _____	
Street Address _____		
City, State, Zip _____		
Phone Numbers	Home _____	Cell _____ Work _____
Date of Birth _____	Age _____	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male
Marital Status	<input type="checkbox"/> Single	<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Occupation _____	Employer _____	
Employer's Address _____		
Employer's Phone _____		
In case of emergency, contact _____		
Relationship _____		Phone _____
Whom may we thank for referring you to PureLife Chiropractic? _____		
Best way to remind you of next appointment: <input type="checkbox"/> Phone _____		
<input type="checkbox"/> E-mail _____		
INSURANCE INFORMATION		
Who is responsible for this account? _____		Relationship _____
Insurance Co. _____	Group # _____	
Is patient covered by additional insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insured's Name _____	Relationship _____	
Insured's Birthdate _____	SS# _____	
Insurance Co. _____	Group # _____	
PATIENT CONDITION		
Reason for this visit _____		
When did symptoms appear? _____		
Is condition getting progressively worse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you seen another doctor for this condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If Yes, whom? _____
Is this injury related to an accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Car Accident <input type="checkbox"/> Work Related
	<input type="checkbox"/> Slip/Fall	<input type="checkbox"/> Other _____
To whom have you reported this injury?	<input type="checkbox"/> Auto Insurance	<input type="checkbox"/> Employer
	<input type="checkbox"/> Workers' Comp	<input type="checkbox"/> Other _____
Attorney name, if applicable _____		
Have you been treated for any health conditions by a physician in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please describe _____		

I hereby authorize my insurance company benefits to be paid directly to PureLife Chiropractic
I realize I am responsible to pay for any non-covered services. I hereby authorize the release of
pertinent information to the insurance company.

Patient or Legal Representative Signature _____ Date _____