



# FORTIER CHIROPRACTIC HEALTHCARE

*Auto Accident • Work Injury • Back Pain • Headache • Sports Injury*  
220 Fifth Avenue SW Albany, OR 97321 Ph.(541) 926-0510 Fax(541) 926-5540  
[www.fortierchiropractic.com](http://www.fortierchiropractic.com)

## CONFIDENTIAL NEW PATIENT REGISTRATION

*Thank you for choosing our practice for your health care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help!*

Today's Date \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle Init.

Address \_\_\_\_\_  
Street Apt# City State Zip

Marital Status: M / W / S / D / Sep. DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Sex M/F

Phone H (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ W (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_ C (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

E-mail Address: \_\_\_\_\_ Employer/Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

Is this visit routine/accident/illness/other: \_\_\_\_\_ If Accident (date) \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

## RESPONSIBLE PARTY INFORMATION

Name (Guarantor) \_\_\_\_\_  
Last First Middle

Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Street City State Zip

Employer/Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

\*\*Please notify our front office staff if there is an alternate address / phone number or form of communication that you wish us to contact you by other than your listed information above.

