



REGISTRATION INFORMATION

PERSONAL AND WORK INFORMATION

First Name _____ Last _____ Date ____ / ____ / ____
Name I prefer to be called _____ Date of Injury ____ / ____ / ____
Address _____ Apt# _____ City _____ State _____ Zip _____
Home Phone () _____ Cell Phone () _____ Birthdate ____ / ____ / ____
Are you ()Male ()Female Are you ()Single ()Married ()Widowed ()Divorced ()Separated
Who may we THANK for referring you _____ Number of Children _____
Social Security Number _____-_____-____ Email Address _____
Occupation _____ Employer _____ Bus Phone () _____
Bus Address _____ City _____ State _____ Zip _____
SPOUSE First Name _____ Last _____ Birthdate ____ / ____ / ____
Occupation _____ Cell Phone () _____ Work Phone () _____
Emergency Contact Name _____ Phone () _____

FINANCIAL AND INSURANCE INFORMATION

My account will be handled by()Health Insurance ()Self Pay ()Work Comp ()Personal Injury ()Other
Insurance Company _____ Insured Birthdate ____ / ____ / ____
Name of Insured _____ Relation to patient _____
ID# _____
Group# _____
Do you have additional insurance? ()YES ()NO
Insurance Company _____ Insured Birthdate ____ / ____ / ____
Name of Insured _____ Relation to patient _____
ID# _____
Group# _____

RESPONSIBLE PARTY (Only complete this section if you **ARE NOT** the patient but are responsible for the bill Ex: Parent)

Responsible Person _____ Relation to Patient _____
Address _____ Apt# _____
City _____ State _____ Zip _____ Phone () _____
Occupation _____ Employer Name _____

CONSENT FORM AND AGREEMENT

Chiropractic examination and therapeutic procedures (Including, but not limited to: Chiropractic Manipulation, Exercise Rehabilitation, Soft Tissue Massage and Manual Muscle Therapy) are considered safe and effective methods of care. However, occasionally, complications may arise. While these complications are very rare and minor, it is the policy of this office to inform our patients of them. These complications may include but are not limited to: soreness, inflammation, soft tissue injury, dizziness and temporary worsening of symptoms. More serious complications are extremely rare. Additional information on risks and side effects is available on request. Please ask your treating Physician any questions you may have. There are no guarantees for a specific cure or result.

RECORDS RELEASE AND ASSIGNMENT OF BENEFITS

The undersigned hereby authorizes the **Release of any Information** relating to claims for benefits submitted. I further agree and authorize my Physician to submit claims for benefits and for services rendered, without obtaining my signature on each claim. I also authorize my Insurance Company to pay and assign directly to Dr. Nadeem A. Bajwa and Seattle Chiropractic & Massage Center all owed benefits. I understand I am ultimately financially responsible for all charges incurred.

NAME _____ **SIGNATURE** _____ **DATE** _____