

**PATIENT REGISTRATION FORM**  
**East Vancouver Chiropractic Clinic**  
**Nicholas M. Peck, D.C.**

Patient	(Please Print)	Today's Date
<input type="checkbox"/> New <input type="checkbox"/> Existing		/    /

**PATIENT INFORMATION**

Please Print Your Name *As It Appears On Your Insurance Card*

Last Name	First Name	Middle

What Name Do You Prefer To Be Addressed By?	
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Home Address	Mailing Address
City                      State                      Zip Code	City                      State                      Zip Code

Gender	Date Of Birth	Age	Social Security Number	Marital Status (Circle One)
<input type="checkbox"/> F <input type="checkbox"/> M	/    /			Single    Married    Divorced    Separated    Widowed

Home Phone	Cell Phone	Email Address	Work Phone	Ext.
(    )	(    )		(    )	

May we leave voicemail messages?	At Your Home:	<input type="checkbox"/> Yes <input type="checkbox"/> No	At Your Work:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**IN CASE OF EMERGENCY**

Emergency Contact 1	Home Phone	Work Phone	Ext.	Relationship To Patient
	(    )	(    )		

May we communicate with this person about your health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Emergency Contact 2	Home Phone	Work Phone	Ext.	Relationship To Patient
	(    )	(    )		

May we communicate with this person about your health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**EMPLOYMENT INFORMATION**

Employment Status

<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Not Employed <input type="checkbox"/> Active Military <input type="checkbox"/> Self Employed <input type="checkbox"/> Retired <input type="checkbox"/> Student <input type="checkbox"/> Other:
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Occupation	Employer	Employer Phone
		(    )

Employer Address	City	State	Zip Code

**PHYSICIAN INFORMATION**

Referring Physician	Primary Care Physician

(Continued On Other Side)

### INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

<b>Primary Insurance Company</b>	Group Number	Insurance Id. Number	Co-Pay
Patient's Relationship To Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			

#### Subscriber Information

Last Name	First Name	Gender	Date Of Birth	Employer
		<input type="checkbox"/> F <input type="checkbox"/> M	/   /	

### INSURANCE INFORMATION

<b>Second Insurance Company</b>	Group Number	Insurance Id. Number	Co-Pay
Patient's Relationship To Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other:			

#### Subscriber Information

Last Name	First Name	Gender	Date Of Birth	Employer
		<input type="checkbox"/> F <input type="checkbox"/> M	/   /	

### FINANCIAL RESPONSIBILITY

(If other than patient)

Last Name	First Name	Middle
Mailing Address		Home Phone
		(   )
City		Work Phone
	State	(   )
	Zip Code	Relationship To Patient
		<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other:

### FINANCIAL AGREEMENT — SIGNATURE REQUIRED

I understand that I am financially responsible for all charges rendered by **East Vancouver Chiropractic Clinic** whether or not they are covered by insurance. I hereby give lifetime authorization for payment of insurance benefits directly to **East Vancouver Chiropractic Clinic** accounts. In the event of default I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I have read the above FINANCIAL AGREEMENT and understand it.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Guardian Signature** – If patient is a minor

\_\_\_\_\_  
**Date**