128 Saddle Rd. Suite 100 – Ketchum, Id. 83340
Tel: 208/726-4555 Fax: 208/726-4515

Ketchum Chiropractic

Tom West D.C., Aaron Stern D.C.

NEW PATIENT REGISTRATION

Today's Date_____ Acct#_____ Referred By_____

Name_____ Marital Status_____
Last First Middle spouse name

(Complete Mailing)
Address_____**
Street (or P.O. Box) Apt# City State Zip

Social Security # _____ – _____ – _____ Date of Birth_____Age_____

Home Phone # (_____)_____–_____** Work Phone # (_____)_____–_____**

Cell Phone # (_____)_____–_____** E-mail Address: _____**

Employer_____ Occupation_____ Phone# (_____)_____–_____

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

If this is the result of an accident, where did it take place (work, car, home, etc.)_____

Emergency Contact_____ Relationship_____ Phone# (_____)_____–_____

RESPONSIBLE PARTY INFORMATION

Name (Guarantor)_____
Last First Middle

Relationship to Patient _____

Address _____ Phone# (_____)_____–_____
Street City State Zip

Employer_____

Address_____ Phone #(_____)_____–_____

Name of Insurance_____ ID#_____Grp#_____

(please complete insurance form)

**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.

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ACKNOWLEDGEMENT AND UNDERSTANDING

Please initial each item below.

1. _____ I hereby authorize Ketchum Chiropractic to provide Chiropractic Services for me.

2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Ketchum Chiropractic Clinic.

3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. _____ I hereby assign all chiropractic benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans, to Ketchum Chiropractic Clinic, 128 Saddle Rd., Suite 100 – Ketchum, Id. 83340

5. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

Dated this _____day of _____ 20_____.

_____
Patient Signature

_____
Guarantor Signature **Relationship to Patient**

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I hereby authorize treatment for the following:

_____ DOB _____
Patient's full name

to any chiropractic treatment deemed advisable , if a parent or legal guardian is not available when the child is brought in for treatment.

This authorization will be effective as of _____ and expires _____.

Signature_____Witnessed by _____
(Parent or Guardian)