LEADING EDGE CHIROPRACTIC, LTD. 10635 PROFESSIONAL CIRCLE
PROSPINAL INC SUITE B, RENO NV, 89511

Patient Registration Form

Patient Information

_____ _____
(First, Middle, Last Name) *(Date of Birth)*

_____ _____
(Address) *(City, State, Zip Code)*

_____ _____ _____
(Home Telephone Number) *(Work Telephone Number)* *(Social Security Number)*

_____ _____ _____
(Cellular Phone Number) *(Nickname)* *(Prior Name)*

_____
(Email Address)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Sex: ☐ Male ☐ Female
Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student ☐ Other

Employment Information

_____ _____
(Occupation) *(Employer)*

_____ _____
(Address) *(City, State, Zip)*

Spouse Information

_____ _____
(Name) *(Date of Birth)*

_____ _____
(Social Security Number) *(Occupation)*

_____ _____
(Employer) *(Employer Phone Number)*

Responsible Person (If Applicable)

_____ _____ _____
(Name) *(Date of Birth)* *(Relationship to Patient)*

_____ _____
(Address) *(City, State, Zip Code)*

_____ _____ _____
(Phone Number) *(Social Security Number)* *(Occupation)*

_____ _____
(Employer) *(Employer Phone Number)*

Relative to Contact In Case of Emergency (Out of Household)

_____	_____	_____
(Name)	*(Phone Number)*	*(Relationship to Patient)*
_____	_____	
(Address)	*(City, State, Zip Code)*	

Insurance Information

_____	_____	_____
(Name of Insured)	*(Date of Birth)*	*(Relationship to Patient)*
_____	_____	_____
(Insurance Company)	*(Group Number)*	*(ID Number)*
_____	_____	
(Address)	*(City, State, Zip Code)*	

How were you referred to our office?

❑ **By an Attorney** ❑ **By a Doctor** ❑ **By a Patient** ❑ **Other**	**Please print the name of your source below.** _____

Is your injury or illness related to any of the following?

❑ **Employment** ❑ **Emergency** ❑ **Accident** ❑ **Auto Accident**	**If Auto Accident, please print the state where the accident occurred below** _____

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment.

Financial Responsibility and Assignment of Benefits

I agree to pay all charges for medical and health care services not covered by my insurance company.

I certify that I have read this form and understand its contents.

_____	_____
(Patient or Other Legally Authorized Person)	*(Date)*