D'Youville COLLEGE
Educating for life

□ Hageman Chiropractic Health Center, 320 Porter Ave, Buffalo, NY 14201 P: 716-829-7991 F: 716-829-7893
□ Chiropractic Health Center, 2900 Main St., Buffalo, NY 14214 P: 716-923-4375 F: 716-923-4379
□ Erie County Med. Center, 462 Grider St., Buffalo, NY 14214 P: 716-898-4202 Fax: 716-898-5175

Registration Form

Today's Date: _____/_____/ 2016

Patient Information

Patient Name: _____ Gender M F Marital Status: M S D W

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we leave a voice message ? Yes /No What number do you prefer for messages? _____

Age: _____ DOB: _____ Are you: DYC Faculty/Staff DYC Student Non-DYC Student DYC Alumnus

Race_____ Ethnicity_____ Preferred Language_____

Email Address: _____

Have you ever been treated by a Chiropractor?_____ When Last_____

Occupation: _____ Current Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Spouse Name: _____ Employer: _____

In Case of Emergency Contact: Name: _____ Phone: _____

Relationship to Patient: _____

How did you learn about our clinic? _____

Referred to Clinic by: _____ Appt. made by: _____

Primary Care Physician: _____

Office Address: _____ Office Phone: _____

Date of last visit to Primary Care Physician: _____

Are you currently being treated for any condition(s)? If so, what condition? _____

_____

If yes, by whom? _____

Are you taking any medications? Y N If yes, please list them _____

_____

(over)

CURRENT PROBLEM

Reason for this appointment: _____

Other doctors consulted for this condition: _____ _____

Is your condition accident related? N Y What area was injured?_____

If yes; Type of accident: □Vehicular (No Fault) □Work related (Workers Comp) □Personal Injury

Date of accident: _____ Case number:_____

*****PLEASE PROVIDE COPY OF ACCIDENT REPORT*****

Imaging Studies: (circle all that apply) X-ray, CT scan, MRI, bone scan, other: _____

Body area imaged: _____ Facility: _____ Date: _____

Insurance Information: (Please present your insurance card to the front desk)

Name/Address of Insurance Company: _____

Insured's Name: _____ DOB: ____/_____/____ ID# or Claim # _____

Insured's Address: _____

Relationship to Patient: □ Self □ Spouse □ Parent □ Other

Person Responsible for Payment: _____

The above information is true to the best of my knowledge. If applicable, I authorize my insurance benefits to be paid directly to D'Youville College. I understand and agree that I am personally responsible for payments of fees incurred at this office.

I also understand that if I am responsible for a copayment by my insurance company, it is due on the day of the visit.

After the initial visit, should you envision having financial challenges with our fee schedule, you may be eligible for a financial discount. If you feel you are in need of such financial assistance pertaining to our fees, please advise us so we can provide you with the necessary paperwork to determine your eligibility. Be advised that financial assistance discounts are not retroactive and subject to reimbursement if compensation is rewarded through a personal injury settlement.

Consent for Professional Services

In order to establish a treatment plan, the Doctor of Chiropractic Clinician and/or Intern must perform an examination and may request other clinical services to determine the exact cause of your complaint(s). I hereby authorize the doctor and whom-ever they designate to administer a physical examination, radiographic studies, laboratory procedures or any other clinical service deemed necessary to reach a clinical decision/diagnosis needed to develop an appropriate treatment plan. I also understand that the Clinician and/or Intern may perform some procedures or maneuvers that are intended to reproduce my symptoms and could cause a temporary aggravation of my symptoms.

Patient's Signature: _____ Date: _____

Parent/Guardian's Signature, if minor: _____Relationship: _____

Witnessed By: _____ Date: _____