



3735 SE Division St. Portland, OR 97202 - Phone: 503-914-6521 Fax: 503-488-5584 - Email: info@ridgelinechiro.com

Acct#: _____

New Patient Registration

Today's Date _____

Name _____
Last First Middle

Social Security # _____ - _____ - _____ Date of Birth _____

Address _____
Street Apt# City State Zip

Contact Phone # (____) _____ - _____ Work Phone # (____) _____ - _____

E-mail Address: _____

Employer _____ Occupation _____ Phone# (____) _____ - _____

Name of Insurance _____ ID# _____ Grp# _____

Emergency Contact _____ Relationship _____ Phone# (____) _____ - _____

How did you hear about us? _____

RESPONSIBLE PARTY INFORMATION (if applicable)

Name (Guarantor) _____
Last First Middle

Relationship to Patient _____

Address _____ Phone# (____) _____ - _____
Street City State Zip

Employer _____

Address _____ Phone # (____) _____ - _____

Acknowledgement and Understanding

Please initial each item below.

1. _____ I hereby authorize Ridgeline Clinic to provide chiropractic and bodywork services for me.
2. _____ I understand and agree that regardless of insurance coverage, I am liable for any and all charges incurred as a result of services rendered to me at Ridgeline Clinic.
3. _____ If this account is assigned to an attorney for collection and/or suit, the Ridgeline Clinic shall be entitled to reasonable attorney's fees and cost of collections.
4. _____ I hereby assign all chiropractic and bodywork benefits, including major medical benefits to which I am entitled, Medicare, private insurance and all other health plans to: Ridgeline Clinic – 3735 SE Division St. Portland, OR 97202.

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

Today's Date _____

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:

Patient's full name

DOB _____

to any chiropractic or bodywork 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)