Dr. Rob Bodner, LMT, D.C. - Phone: 503-914-6521 Fax: 503-488-5584 - 3735 SE Division St. Portland, OR 97202

New Patient Registration

Today's Date___________________

Name____
Last First Middle

SS# _______________________ Preferred Pronoun______ Date of Birth_________________________

Address____
Street City State Zip

Contact Phone # (_____)________–______________ Work Phone # (_____)_________–____________

E-mail: ____

Employer_______________________ Occupation_____________________

Name of Insurance______________________ ID#____________________ Group# _________________

Primary Doctor _________________________________ Phone# (_____) ________ - __________

Emergency Contact ___________________ Relationship____________ Phone# (_____) _______–________

How did you hear about us? ____

Responsible Party Information (if applicable)

Name(Guarantor)____
Last First

Relationship to Patient ____

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 agree to cancel appointments 24 hours in advance. I understand there may be a fee incurred for appointments cancelled less than 24 hours for either massage or chiropractic. ________
5. I understand that my insurance may not reimburse an adequate amount for a massage that was billed and I will be responsible for the remainder. ________

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:

____ DOB _____________________
Patient's full name

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)