



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# xxx-xx- _____ Preferred Pronoun _____ Date of Birth _____

Address _____
Street City State Zip

Contact 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# (____) _____ - _____

Authorization To Treat A Minor

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

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 _____ (Parent or Guardian)



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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