Dr McMakin's Chiropractic FSM Clinic

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Chiropractic Physician • Diagnosis + Treatment of Chronic Pain • Frequency Specific Microcurrent

PATIENT REGISTRATION INFORMATION

Patient name: _____ Date of birth: _____

☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say

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

Home phone: _____ Work phone: _____ Cell phone: _____ Email: _____

Social Security # _____ Drivers Lic. # _____ State: _____

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Work status: ☐ Full ☐ Part ☐ Unemployed

Employer name: _____

Employer address: _____ City: _____ State: ____ Zip: _____

Responsible party: _____ Relationship: _____

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

Home phone: _____ Work phone: _____ Emergency contact: _____ Phone: _____

Is this regarding a work injury/illness? ☐ Yes ☐ No Date of injury: _____

Is this regarding a motor vehicle accident? ☐ Yes ☐ No Date of injury: _____

Address/location where accident/injury occurred:

Is this an open claim? ☐ Yes ☐ No

Insurance adjuster: _____ Phone: _____

Have you had an independent medical exam? ☐ Yes ☐ No Date of independent medical exam:

Attorney name: _____ Phone: _____

Insurance Co: _____ Phone: _____

Claims billing address: _____ City: _____ State: ____ Zip: _____

Policy/claim or ID# _____ Group # _____

Policyholder's name: _____ Relationship: _____

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

Home phone: _____ Work phone: _____ Social Security # _____ Date of birth: _____

Employer: _____ Phone: _____

Who may we thank for referring you? _____

Person completing form printed name: _____

Signature of person completing form: _____ Date: _____

Form submitted by: ☐ Dr Carolyn McMakin ☐ Dr Sandra Osterberg