REGISTRATION

Patient_____
Last Name First Name Initial
Home Phone_____Cell Phone_____Email_____
Address_____
City_____ State_____ Zip_____
Sex □ M □ F Age_____ Birth date_____□ Single □ Married □ Widowed □ Separated □ Divorced
Social Security #_____ Driver's License #_____
Policy Holder _____DOB_____SSN_____
Relationship to Policy Holder □ Self □ Spouse □ Child □ Other
Condition/ Illness Related To □ Illness □ Employment □ Auto □ Other
How and where did you learn about this clinic?_____

EMPLOYER	Company Name_____ Occupation_____ Address_____ Phone_____□ Full-time □ Part-time City State Zip
SPOUSE (PARENT)	Name_____ Last Name First Name Initial Birthdate_____ Social Security #_____ Employer Name_____ Occupation_____ Address_____Phone_____ City State Zip
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ ID #:_____ Group # _____ Name of Insured:_____DOB_____
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name_____ ID#:_____ Group#:_____ Name of Insured:_____DOB_____
MEDICAL AND LEGAL INFORMATION	Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or other personal injury someone else might be legally liable for? □ **Yes** □ **No** Your Initials:_____ If you answered yes, please fill out accident specific form, available at the front desk. Pregnant □ Yes □ No Pacemaker □ Yes □ No Family Physician_____ Person to contact in emergency (Name and Phone #)_____ Attorney_____ Telephone:_____ Address_____
PATIENT AGREEMENT	**LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to Flag City Sport & Spine all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses. **I acknowledge having the right to review and obtain a copy of the Notice of Privacy Practices of the office. (Once information is disclosed, it may not be protected by law.) Additionally, I give this office the right to use my name in any in office publications.** This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. _____ _____ Signature of Insured / Guardian Date