



Scott Chiropractic and Wellness

801-546-4500

180 West Gordon Ave, Layton, UT 84041 Confidential Health Information **Patient Registration**

Patient Name: _____ Soc. Sec. #: _____
Last First Middle Gender
 Date of Birth: _____ Age: _____ Marital Status: S M W D Other Number of Children: _____
Month Day Year
 Home Address: _____
Street City State ZIP
 Home Phone: _____ *Email Address (we keep private): _____
 Cell Phone: _____ ATT Sprint TMob Veriz Employer: _____
 Work Phone: _____ Work Address: _____ City _____ St Zip _____
ALLERGIES YES NO If yes, list all _____ **PACEMAKER** YES NO **Other ELECTRICAL IMPLANT** YES NO

Responsible Party: _____ Birth Date _____ Soc. Sec. #: _____
Last First Middle
 Relationship to Patient: _____ Phone: _____ Home ATT Sprint TMob Veriz _____
 Home Address: _____
Street City State ZIP
 Employer: _____ Occupation: _____
 Work Phone: _____ Address: _____
Street City State ZIP
 Spouse Partner Name: _____ Address: _____ Birth Date _____
 Spouse Partner Employer: _____ Spouse / Partner Occupation: _____
 Spouse Partner Employer Address: _____ Work Phone: _____
Street City State ZIP

Primary Insurance: _____	Secondary Insurance: _____
Employer Issuing Policy: _____	Employer Issuing Policy: _____
Insurance Address: _____	Insurance Address: _____
Phone: _____	Phone: _____
ID #: _____ Group #: _____	ID #: _____ Group #: _____
This Insurance is under the name of: (Insured Person) _____ *Birth Date: _____	This Insurance is under the name of: (Insured Person) _____ *Birth Date: _____

Nearest Relative NOT LIVING WITH PATIENT: _____ Relationship _____
 Name: _____ Phone: (____) _____
 Address: _____ City: _____ State: _____ ZIP: _____

I understand that responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable at time of service unless financial arrangements have been made. I further agree, that if payments are extended beyond 30 days from the date fo first billing to pay 1.5% per month on the unpaid balance (annual rate of 18%) with a minimum of 50 cents per month. I thus waive the Statute of Limitations regarding the physician's right to recover. I/we agree to pay all costs and / or reasonable attorneys fees (not to exceed 50% of total balance due) if any delinquent balance is placed with an agency or attorney for collection of suit.

I hereby authorize and assign all health insurance benefits, including major medical, work comp., personal injury, auto, and any other health plans to which I am entitled to Scott Chiropractic and Wellness. I permit this office to endorse co-issued remittance for the conveyance of credit to my account. I hereby authorize Scott Chiropractic and Wellness to release all information necessary to secure payment. I understand and agree that I am responsible for the charges whether or not paid by said insurance and /or declared not medically necessary by insurance company and/or any review panel.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

The undersigned hereby authorizes Doctor to take x-rays, perform examination and any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's health needs. I also authorize Doctor to perform any and all forms of treatment, supplementation and therapy that may be indicated.

How did you hear about our office? _____ Name of person taking information: _____

Responsible Party: _____ Date: _____