

DrOhmyback.com

Patient Registration

PEACE OF MIND, BALANCED BODY™

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful and educational.

Confidential health information

1 PATIENT CONTACT		Clinic id	Date
Last name	First name	m.i.	
Preferred to be called			
Street			
City	State	Zip	
Home phone	Mobile phone		
Work phone	e-mail		

2 PATIENT PERSONAL	age	Date of birth / /	Social security # - -	Sex	male	female
status	single	married	partnered	widowed	separated	divorced

3 EMERGENCY CONTACT	Name	Home phone
Relationship	Work phone	

4 SPOUSE OR GUARDIAN	Last name	First name	m.i.
Employer name			
Work phone	Date of birth / /	Social security #	

5 PATIENT EMPLOYMENT	Employer name	occupation
street		
City	State	Zip

Which one of our patients referred you to our clinic?

Today we will conduct a thorough history, consultation, and preliminary screening. If we believe we may be able to help you, we may recommend other diagnostic testing necessary to evaluate your condition. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

I understand agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes. I am requesting these services.
- My case may not be accepted for treatment at this clinic.
- If the doctors believe that I may respond to their care, additional service may be recommended and I will be advised of applicable cost.

By my eSignature below, I certify that I have read, fully understand and accept all terms of the foregoing statement. Please signify your acceptance by entering the information requested in the fields below.

Full Name:

Date: / /