

Patient Registration

Welcome to our office! The following information is necessary for us to assist you and is essential for the management of any insurance claim filing. **Please Fill Out Completely.** If you do not understand a question or need assistance, please ask us. Thank you.

Last Name: _____ First Name _____ MI _____ Age _____ Sex: Male Female

Street Address: _____ City: _____ St.: _____ Zip: _____ Phone: _____

Social Sec#: _____ CDL#: _____ Birthdate: _____ / _____ / _____ Marital Status _____

Spouses Name: _____ Spouses Social. Sec#: _____

Contact in an Emergency: Name _____ Relationship _____ Phone _____

Credit Information: Bank: _____ Branch: _____ Checking Savings

Nearest Relative Not Living With You

Name: _____ Relationship: _____

Address: _____ City: _____ St.: _____ Zip: _____ Phone: _____

Is your complaint due to a:

Work Injury? Yes No **Auto Accident?** Yes No **Other Accident?** Yes No

If this is a work injury, have you reported it to your employer? Yes No

Are you represented by an Attorney? Yes No **Attorney Name:** _____

Employment Information:

Your Employer: _____ **Supervisor:** _____

Address: _____ City: _____ St.: _____ Zip: _____ Phone: _____

Job Title: _____ How Long Employed There? _____

Please Describe Your Job: _____

Primary Medical /Group Insurance Information:

Insurance Company: _____

Address: _____ City: _____ St.: _____ Zip: _____

Phone: _____ Group#: _____ ID#: _____ Plan#: _____

Through Your Employer? _____ Or Spouse's? _____ Name of Secondary Insurance: _____

Secondary Medical /Group Insurance Information:

Insurance Company: _____

Address: _____ City: _____ St.: _____ Zip: _____

Phone: _____ Group#: _____ ID#: _____ Plan#: _____

Through Your Employer? _____ Or Spouse's? _____ Name of Secondary Insurance: _____

Acknowledgment and Understanding: (Please read completely and sign below)

I acknowledge and understand that insurance policies are an agreement between myself and an insurance carrier.. **I clearly understand that all services rendered to me by William C. Hamilton, D.C. are charged directly to me and that I am personally responsible for payment.** I also understand that if I suspend or terminate my care and or treatment, any fees for professional services rendered me will be immediately due and payable. I further authorize you to release any information regarding my medical condition to any insurance company, adjuster or attorney or their agents in order to process any claim for service rendered to me.

Patient Signature: X _____ **Date:** _____

Dr. William C. Hamilton, DC 17760 Monterey Road, Suite A4, Morgan Hill, CA 95037

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

1. I, _____, hereby acknowledge and agree that I am receiving or about to receive Chiropractic care services from William C. Hamilton, D.C. .
2. I acknowledge and understand that insurance policies are an agreement between myself and any insurance carrier. I clearly understand that all services rendered to me by William C. Hamilton, D.C. are charged directly to me and that I am personally responsible for payment. I also understand that if suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.
3. I hereby authorize William C. Hamilton, D.C. to release any information deemed appropriate concerning my physical condition to any insurance company, adjuster or attorney in order to process any claim for re-imbusement of charges incurred for services rendered me by him or any member of his staff acting in his behalf.
4. In the event any insurance company, adjuster or attorney obligated by contractual agreement to make payment to me or to William C. Hamilton, D.C. for the charges made for service, refuses to make such payment upon demand, I hereby authorize William C. Hamilton, D.C. or his assigns to prosecute such action either in my name or his name to resolve said claim and collect legal expenses as he sees fit.
5. I fully understand that I am responsible for all charges whether or not paid by any third party. I agree that all charges are payable and collectable in the county of Santa Clara, Ca. I hereby further specifically authorize William C. Hamilton, D.C. to make inquiries, endorse drafts and to release information to my insurance company, employer, attorney or benefit plan about my case and **I hereby give an irrevocable lien on my case to William C. Hamilton, D.C. against any and all proceeds of my settlement, judgment or verdict whether such proceeds arise from medical or other damages which may be paid either to me or to my attorney.**
6. I further irrevocably **authorize** and **direct** any of these agents to pay what is due for professional services directly to William C. Hamilton, D.C. .
7. I hereby give express permission to William C. Hamilton, D.C. to administer and perform such examinations, treatments and general procedures as he deems necessary in the diagnosis and treatment of my condition.
8. I acknowledge that I have read the above and have received a copy of this agreement and agree that a photocopy of this document will be deemed as valid and binding on all parties as the original agreement. I further instruct my attorney of record, if any to acknowledge the existence of this lien and abide by the terms thereof.

Signed: _____ Date: _____
Patient Signature

On behalf of the above patient, I hereby acknowledge receipt of this lien and agree to the terms thereof.

Signed: _____ Date: _____
Attorney for the patient

Attorney: Please sign above, make a copy for your records and return the original to the above address

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I _____ hereby acknowledge and agree that I am, or about to become, a patient of Dr. William C. Hamilton, D.C. and have requested and consent to the performance of chiropractic examination, adjustments and other chiropractic procedures including various modes of physical therapy, and diagnostic x-rays on me (or the patient named below, for whom I am legally responsible) by Dr. William C. Hamilton, D.C. and /or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back up for Dr. William C. Hamilton, D.C., including staff members and other assistants working at the clinic or office or any other office or clinic.

I have had an opportunity to discuss with Dr. William C. Hamilton, D.C. and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures.

I therefore understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to; fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on Dr. William C. Hamilton, D.C. to exercise judgment during the course of the procedure which he feels at the time, based on the facts then known, is in my best interests.

I have read, or had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I may seek treatment.

X _____
Patient Signature

Date

Dr. William C Hamilton, DC 17760 Monterey Road, Suite A4, CA 95037

Pain Drawing

Patient Name: _____

Date: _____

Please indicate on the drawing below the type and location of your sensations.

Key:

A=Ache

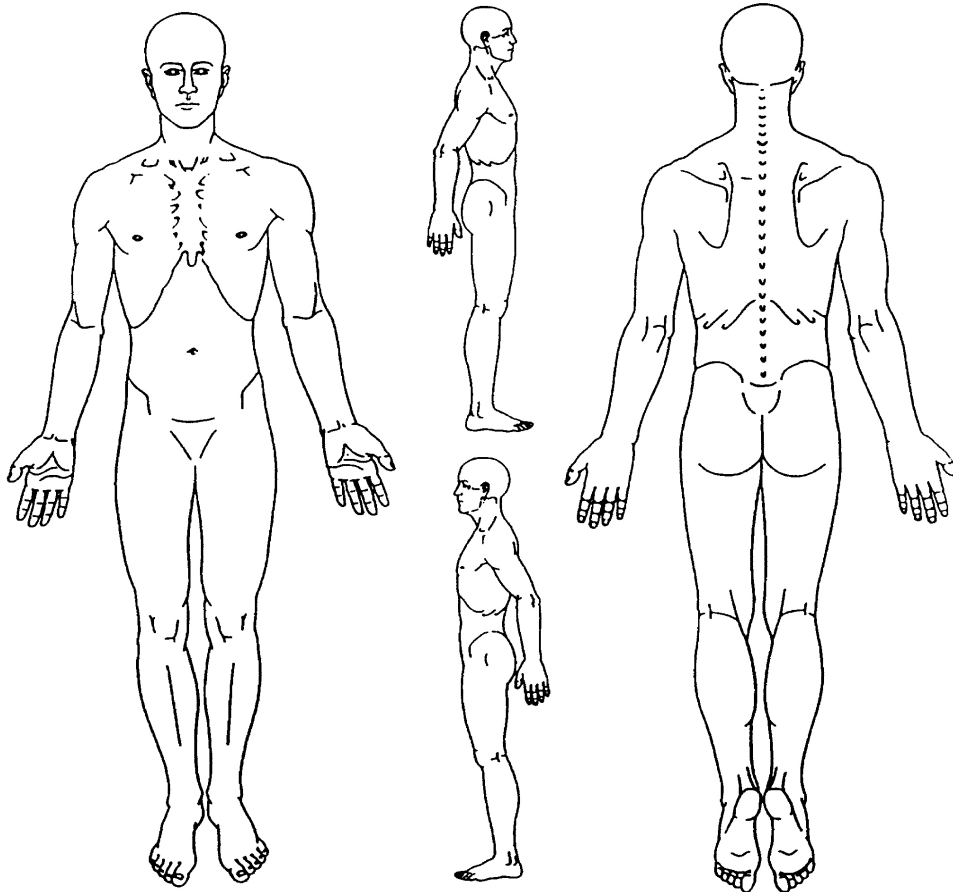
P=Pins and Needles

B=Burning

S=Stabbing

N=Numbness

O=Other



Please indicate the overall level of your pain on the line below with a single slash (/)

No Pain _____ Extreme Pain

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