Meridian Chiropractic Center
George R. Meluch, D.C.
Heather A. Dorey, D.C.

# New Patient Registration

Patient ID Label

## General Information

**Name** _____

**Street Address** _____

**Zip** _____ **City** _____ **State** _____

**Birthdate** ____/____/____ **Age** _____ **Social Security #** _____-____-_____

**Gender** ☐ Male ☐ Female

**Marital** ☐ Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐ Separated ☐ Divorced

**How did you hear about our office?**

☐ From one of our patients? Name _____

☐ From a physician or health care practioner? Name _____

☐ From other source? Please Specify
_____

**Phone (home)** _____-_____-_____ **Phone (Work)** _____-_____-_____

**Phone (other)** _____-_____-_____ **Email** _____

## Insurance Information

**Do you have insurance?** ☐ Yes ☐ No **Policy Holder?** ☐ Self ☐ Spouse ☐ Parent

**Insurance Carrier 1** _____ **Plan Name** _____

**Insurance Carrier 2** _____ **Plan Name** _____

**Insurance Carrier 3** _____ **Plan Name** _____

**Employer (of policy holder)** _____

**Address** _____ **Zip** _____ **City** _____ **State** ____

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## Privacy Policy at Meridian Chiropractic Center

I acknowledge that the Notice of Privacy Practices (the Notice) for Meridian Chiropractic Center (the Center) has been provided to me. The Notice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of the Center. The Notice is also provided on request at the administration desk of the Center. This Notice also describes my rights and the Center's duties with respect to my protected health information.

The Center reserves the right to change the privacy practices that are described in the Notice. I may obtain a revised Notice by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I hereby authorize the Center staff to use my name, address, telephone number, email address and clinical records to contact me with appointment reminders, birthday, holiday, or sympathy cards, newsletters, or other health-related or clinic policy information. If contact is made by telephone, a message may be left on my answering machine.

I understand I have the right to refuse to give this authorization. I have been assured that such refusal will not affect the treatment provided or methods used for reimbursement of care.

This notice is effective April 1, 2003 and expires seven years after my last date of service at the Center.

**Patient Signature** _____ **Date** ____/____/____

## Consent for Care

I hereby authorize Meridian Chiropractic Center and its doctor(s) to administer care as they deem necessary to me:

**Patient Signature** _____ **Date** ____/____/____

## Consent for Care of a Minor

I hereby authorize Meridian Chiropractic Center and its doctor(s) to administer care as they deem necessary to my minor child:

**Parent/Guardian Name** _____ **Relationship to Patient** _____

**Parent/Guardian Signature** _____ **Date** ____/____/____