REGISTRATION

937-439-5400
2165 Miamisburg-Centerville Road • Dayton, OH 45459
www.KSChiro.com

NAME: ____
(Last) (First) (Initial) (What would you like to be called?)

DATE OF BIRTH: ____________________ AGE: ________

ADDRESS: ____
(Street) (City) (State) (Zip)

TELEPHONE: Home ( ) ____________ Work ( ) ____________ Cell ( ) ____________

EMAIL ADDRESS: ____

OCCUPATION: ____________________ WHERE EMPLOYED: ____________________

CIRCLE ONE: Married Single Widow(er) Divorced Separated

PERSON RESPONSIBLE FOR PAYMENT: (If other than yourself) ____________________

IN CASE OF EMERGENCY, CALL: ____________________ (_____)____________________
(Name) (Phone) (Relationship)

FAMILY DOCTOR: (Name) ____________________ (Phone) (_____) ____________________

MAY WE SEND A REPORT TO YOUR FAMILY DOCTOR? Yes ________ No ________

NOTICE OF PAYMENT: Full payment for services rendered is due at the end of each visit. If, for any reason, this request cannot be met, arrangements must be made before seeing the doctor. On all insurance assignments, the deductible and co-payment must be met as services are rendered.
RELEASE OF MEDICAL RECORDS: I agree to release medical records, reports and test results to my insurance company, attorney or adjuster, in order to process any claim of reimbursement of charges incurred by me as a result of professional services rendered and hereby release him/her of any consequence thereof.
AUTHORIZATION: I authorize payment to be paid directly to Drs. Konicki and Schumacher for my Chiropractic expenses. I agree that a photostatic copy of this agreement shall serve as the original.

SIGNED: ____ DATE: ____________________