ELEVATE
SPORT & SPINE THERAPY

Elevate Sport & Spine Therapy • 1660 S Albion St • Denver, CO 80222

Phone: 720-263-0594 • Fax: 720-210-9236 • www.elevatesportandspine.com

NEW PATIENT REGISTRATION

First Name_____ MI:_____ Last Name_____

Address_____
Street Apt# City State Zip

Social Security # _____ – _____ – _____ Date of Birth_____

Home Phone # (_____)_____–_____ Cell Phone # (_____)_____–_____

E-mail Address: _____

Employer_____Occupation_____ Phone# (_____)_____–_____

Employer Address_____
Street City State Zip

Emergency Contact_____ Phone# (_____)_____–_____

Whom may we thank for referring you to our office?_____

Who is your current primary care doctor?_____

May we contact them with updates about your care here?_____

Acknowledgment and Understanding

Please initial each item below.

1. _____ I hereby authorize Elevate Sport & Spine Therapy to provide Chiropractic Services for me.

2. _____ I understand and agree that regardless of insurance coverage, I am liable for any charges incurred as a result of services rendered to me at Elevate Sport & Spine Therapy.

3. _____ If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collections.

4. _____ I authorize release of patient's records to third parties requiring these records for determination of financial liability.

By signing this application I affirm under penalty that I have given true complete information.

Dated this _____day of _____ 20_____.

_____
Patient Signature

_____
Guarantor Signature **Relationship to Patient**