Gallatin Valley Chiropractic PLLC
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Dr. Dustin Rising
Licensed Chiropractor

Patient Registration and History

Please take a moment to complete the following intake form so we may obtain all necessary information in regard to your care. If you have any questions please ask our office staff for assistance.

General Information

Date ___/___/___

Last Name _____ First Name _____ MI _____

Preferred Name (nickname) _____ Date of Birth ___/___/___ Age _____ ☐ Male ☐ Female

Street Address _____ City _____ State _____ Zip _____

Home Phone (___)_____ Cell Phone (___)_____ Email _____

Social Security # _____ Employer/School _____ Work Phone (___)_____

Occupation _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Spouse/Partner's Name _____ Phone (___)_____

Emergency Contact _____ Relation _____ Phone (___)_____
(other than above)

Referred by _____

Insurance Information (please present all insurance cards for photo copying)

Current Health Insurance Coverage ☐ Medicare ☐ Medicaid ☐ Health Insurance/Other ☐ None

Primary Insurance Carrier _____ Name of Insured _____

Relation _____ Insured DOB _____ Health Savings/Reimbursement account? ☐ Yes ☐ No

Secondary Insurance? ☐ Yes ☐ No if yes, Secondary Insurance Carrier _____

Name of Insured _____ Relation _____ DOB _____

Is current condition related to an accident? ☐ No ☐ Yes if yes please provide date of accident _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other _____

To who have your made report of your accident? ☐ Auto Insurance ☐ Employer ☐ Other _____

Accident/Injury Insurance _____ Claim # _____

Attorney _____ Phone _____