

Patient Registration

Office of James D. Olin, D.C.
229 W. Washington
Sherman, TX 75090
(903) 892-3471

Please Print

Date: _____

First Name Middle Name Last Name
Address: _____ City, State, Zip: _____
SS#: _____ DL#: _____ DOB: _____ Age: _____
Employer: _____ Occupation _____
Address: _____ Marital Status: S / M / D / W
Home Phone: _____ Cell Phone: _____ Work Phone: _____
May we contact you by e-mail: Yes or No E-mail Address: _____
Who referred you to our office?: _____ Student: Full/Part time

Spouse/Legal Guardian

Name: _____ DOB: _____ SSN: _____
Employer: _____ Address: _____
City: _____ State: _____ Zip _____ Employer Phone: _____

Date of Injury/Onset: _____ Dominant Hand: Right / Left / Both

Description of Accident/Injury/Onset of symptoms Enter a full description in the space below

Emergency Contact (someone that does not live with you):

Name: _____
Address: _____ Phone: _____

AUTHORIZATION RELEASE

In consideration of your undertaking to care for me, I agree to the following:

1. You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.
2. I hereby waive the statuted of limitations on collection and/or recovery in this State of **Texas**.
3. I further agree that this Authorization is irrevocable and ongoing.

Patient's Signature: _____ **Date:** _____
Guardian Signature: _____ **Date:** _____