Patriot Chiropractic Center
3915 Old Lee Hwy, Ste. 22C
Fairfax, VA 22030
(703)385-7007 Fax (703)385-4384
patriotchiropractic@verizon.net

CONFIDENTIAL PATIENT REGISTRATION

PATIENT INFORMATION DATE____________________________

PATIENT NAME____
Last Name *First Name* *MI*

REFERRED BY____

ADDRESS____

CITY____ STATE ________________ZIP _________________

SEX ▢ M ▢ F AGE_____ BIRTHDATE_____________________ MARITAL STATUS ▢ M ▢ S ▢ Minor ▢ W ▢ D

OCCUPATION________________________________

PATIENT EMPLOYER/SCHOOL________________________________

WORK PHONE ________________________________

HOME PHONE ________________________________ CELL PHONE ________________________________

EMAIL ADDRESS____

PREFERRED METHOD OF CONTACT ▢ HM PHONE ▢ CELL ▢ EMAIL ▢ TEXT

IN CASE OF EMERGENCY, CONTACT

NAME____RELATIONSHIP____________________________

PHONE ________________________________

NON-PARTICIPATING STATEMENT

I understand that I am financially responsible for all treatment charges and that no treatment codes or charges will be billed to my insurance. I understand if I have chosen a policy with out-of-network benefits that I may request documents to assist in submitting to my insurance myself.

____ ____
Signature of Patient, Parent, Guardian *Print Name of Patient, Parent, Guardian*

____ ____
Date *Relationship to Patient*