Patriot Chiropractic Center
3195 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 PROVIDERS 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*