Patriot Chiropractic Center

Dr. Steven Bernabeu & Dr. Gina Simonetti
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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_____
EMPLOYER/SCHOOL ADDRESS_____
_____
EMPLOYER/SCHOOL PHONE (_____)_____

HOME PHONE (_____)_____ CELL PHONE (_____)_____
EMAIL ADDRESS_____
PREFERRED METHOD OF CONTACT ( )HM PHONE ( ) CELL ( )EMAIL ( ) TEXT

IN CASE OF EMERGENCY, CONTACT
NAME_____RELATIONSHIP_____
PHONE(_____)_____

INSURANCE
WHO IS RESPONSIBLE FOR THIS ACCOUNT?_____
RELATIONSHIP TO PATIENT_____
INSURANCE COMPANY_____
PATIENT ID #_____GROUP #_____
SUBSCRIBERS NAME_____ SUBSCRIBER BIRTHDATE_____
IS PATIENT COVERED BY ADDITIONAL INSURANCE? () YES () NO

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____

INSURANCE COMPANY(IES)

and assign directly to Dr. Steven Bernabeu and/or Dr. Gina Simonetti all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctors may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purposes of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date *Relationship to Patient*

ACCIDENT INFORMATION

IS CONDITION DUE TO MOTOR VEHICLE ACCIDENT? () YES () NO
DATE OF ACCIDENT _____
HAVE YOU REPORTED ACCIDENT TO YOUR HEALTH INSURANCE () YES () NO
HAVE YOU REPORTED ACCIDENT TO YOUR AUTO INSURANCE () YES () NO

I, the undersigned, certify and understand that I am solely financially responsible for all of the treatment charges related to the above referenced motor vehicle accident. I also understand that it is not the responsibility of Patriot Chiropractic Center to file insurance claims with any automobile insurance carrier related to above referenced motor vehicle accident on my behalf and that it is solely my responsibility to do so.

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date *Relationship to Patient*