BENASSI CHIROPRACTIC, P.A.

Patient Registration

Name_____ Date of Birth_____

Address_____

City, State & Zip Code_____

Email_____ Home phone_____

SSN_____ Marital Status_____ Cell phone_____

Employer_____ Work phone _____

Employer's Address_____

How were you referred to us?_____

What symptom are you being seen for

today?_____

Is this an auto or work comp injury?_____ Date of Injury_____

Insurance_____ Policy Holder_____

Address_____ Phone number_____

ID# or Claim #_____ Group #_____

Claim Adjuster_____ Phone number_____

Referring Physician:

Name_____

Address_____

_____

_____

Phone #_____

Fax #_____

Attorney:

Name_____

Address_____

_____

_____

Phone #_____

Fax #_____

Records Release

I consent to the release of medical or related information necessary for treatment and for the processing of insurance claims.

Patient signature_____ Date_____

Assignment of Benefits

I authorize payment of medical benefits to Gina M. Benassi Chiropractic, Inc. In the event the insurance company remits payment directly to the policy holder, I understand the policy holder is responsible for submitting payment directly to Gina m. Benassi Chiropractic, Inc. upon receipt of payment from the insurance company. I understand I may be responsible for any non-covered services, copayments, and deductibles.

Patient Signature_____Date_____