



197 E. Franklin Ave
HoHoKus, NJ 07423
Office: (201) 447-0346
Fax: (201) 447-1582

Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information. Completing this information now will help us start your first visit without delay. All information will be confidential.

Date _____ Patient name _____
First MI Last

SSN _____ - _____ - _____ Birthdate _____ Home phone _____ Cell phone _____

Address _____ Apt No. _____ City _____ State _____ Zip _____

Check appropriate box: Minor Single Married Widowed

Check appropriate box: Male Female

Occupation _____ Employer/school _____ Work phone _____

Address _____ City _____ State _____ Zip _____

Who may we thank for referring you? _____

Person to contact in case of emergency _____ (relationship) _____ Phone _____

Referring physician _____ Diagnosis or part of body being referred for _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Birthdate _____ SSN _____ - _____ - _____

Employer _____ Work phone _____

TURN OVER

Was this injury related to a WORK, AUTO or SCHOOL accident? Yes No

If YES, please check one: work auto school

If YES, DATE OF INJURY _____

If AUTO related, are you currently being treated by a chiropractor? Yes No

Primary Insurance Information

Insurance company _____

Insurance address _____ City _____ State _____ Zip _____

Insurance phone _____ Adjustor name (if applicable) _____

ID or claim # _____ Group # _____

Name of insured _____ Relationship to patient _____

Birthdate _____ SSN _____ - _____ - _____

Secondary Insurance Insurance

Insurance company _____

Insurance address _____ City _____ State _____ Zip _____

Insurance phone _____ ID or claim # _____

Group # _____ Name of insured _____

Relationship to patient _____ Birthdate _____ SSN _____ - _____ - _____

Financial Agreement and Office Policy

I authorize release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I also hereby authorize payment of insurance benefits otherwise payable to me directly to the provider. Should the insurance company(s) not pay in full or at all, I am responsible for any balance remaining on this account.

I understand that a 24-hour advance notice is required for cancellation of an appointment. If the required notice is not given, I may be charged a fee of \$40, in which will be solely my responsibility and no portion will be billed to my insurance carrier. A fee of \$25 will be charged for any returned check.

Please be advised that unless you have Medicare, we are not in-network with your insurance company, but as a courtesy we will submit your bills for you. You will be responsible for any deductible, coinsurance and visits over coverage limitations. Co-insurance payments are due at the time of each visit. If you have a second insurance carrier, we will submit to them also. Once both companies have processed your bills, you will be responsible for any balance remaining. If you have Medicaid as a secondary, you understand we do not participate and agree to pay the 20% Medicare does not cover. Please sign below to acknowledge that you have read and understand our policy.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY) :

() Home Telephone _____

() Work Telephone _____

() OK to leave detailed message

() OK to leave a detailed message

() Leave message with a call back number only

() Leave message with call back number only

Patient signature (or parent if minor)

Date