BERGEN CHIROPRACTIC
and Sports Rehabilitation Center

Patient Information

Name: ______________________ **Date of Birth:** ______________
Address: ______________________
City: ______________________ State: ________ Zip: ______________

Home Phone: ______________________ Male ☐ Female ☐
Cell Phone: ______________________
Email : ______________________

Martial Status
S M D W

Preferred method of contact: Home Number ☐ Work Number ☐ Cell Number ☐ Email ☐

Occupation: ____________ Employer: ____________ Phone: ____________
Address: ____________ City: ____________ State: ______ Zip: ____________

Emergency Contact Name: ______________________ Phone: ____________

Primary Care Physician: ______________________ Phone: ____________
Address: ______________________ Permission to Contact Yes ☐ No ☐
Date of last visit ____________

Who referred you to our office? ______________________

Health Insurance Information – Please present all cards and id for copying
Primary Insurance: ____________ Subscriber same as patient Yes ☐ No ☐
Subscriber's Name: ____________ Date of Birth: ____________
Id / Member Number: ____________ Group Number: ____________
Secondary Insurance: ____________
Subscriber's Name: ____________ Date of Birth: ____________
Id / Member Number: ____________ Group Number: ____________

If accident related: **Date of Accident** ____________
Insurance Name: ____________ Subscriber same as patient Yes ☐ No ☐
Subscriber's Name: ____________ Policy Number: ____________
Adjuster's Name: ____________ Claim Number: ____________
Phone Number: ____________ Adjuster's Fax Number: ____________
Attorney's Name: ____________ Phone Number: ____________
Address ____________ City ____________ State ______ Zip ____________

Please read and sign the following:

Consent to Treat and Authorization of Payment
I the undersigned hereby authorize the Doctor of Bergen Chiropractic and Sports Rehabilitation Center to perform diagnostic tests and to administer treatment as is necessary. I also certify that no guarantee or assurance had been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize my carrier to remit payment directly to this office and I permit this office to endorse remittances as payment toward my account. **However, I clearly understand and agree that all services rendered to me are my personal responsibility.**

Authorization of Release of Records:
I understand and agree to allow Bergen Chiropractic and Sports Rehabilitation Center to use my patient health information for the purpose of treatment, payment, healthcare operations, and coordination of care. I authorize Bergen Chiropractic and Sports Rehabilitation Center to release all information necessary. I also understand that it is my responsibility to inform Bergen Chiropractic and Sports Rehabilitation Center if for any reason there is someone to whom I do not wish to have my records released to.

Patient Signature: ______________________ **Date:** ____________

Guardian's Signature Authorizing Care ______________________ **Date** ____________