



# JAMES S. LEE, D.C.

CHIROPRACTIC PHYSICIAN

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## PATIENT REGISTRATION

Date: \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tel. #: Home \_\_\_\_\_ Mobile \_\_\_\_\_ Work \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender: Male / Female

Email \_\_\_\_\_

Marital Status: Single / Married / Divorced / Separated / Widowed

Social Security # \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Please choose payment method

Private Insurance  Medicare  Medicaid  Workers Compensation  No-Fault  Cash

Insurance Company: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_

Individual or Family Policy: \_\_\_\_\_

Policy Period: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Health Plan or Program Name \_\_\_\_\_

Insurance Card ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Deductible: \$ \_\_\_\_\_ Amount Met: \$ \_\_\_\_\_

Deductible Carryover (If Applicable): \$ \_\_\_\_\_ Co-Pay / Patient Responsibility: \$ \_\_\_\_\_

Have any chiropractic benefits been used this policy period? \_\_\_\_\_

**Reason for visit**

Chief Complaint \_\_\_\_\_

How did you find out about our office? \_\_\_\_\_

Have you been to a Chiropractor before? Yes / No

**No-Fault Patients:**

Date of the Accident \_\_\_\_\_

Auto Insurance Company: \_\_\_\_\_

Auto Insurance Policy #: \_\_\_\_\_

Insurance Claim #: \_\_\_\_\_

Did you notify your insurance company of your accident? Yes / No

Did you file NF2 form? Yes / No

Name of Attorney \_\_\_\_\_

Attorney Address \_\_\_\_\_

Attorney Telephone \_\_\_\_\_