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 _____