SiMPly Chiropractic - Dr. Steven M Poulos DC

PATIENT INFORMATION AND REGISTRATION

If you need any assistance completing this paperwork, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.

File# ______ Date ______

Patient Information

Last Name:	First Name:	M.I.		
Age	D.O.B.	SSN	Gender ☐ Male ☐ Female	
Status ☐ single	☐ married	☐ widowed	☐ separated	☐ divorced ☐ partnered
Street	City	State	Zip	
Work Phone	Home Phone	Cell Phone	e-mail	
Spouse/Guardian Last Name:	First Name:	M.I.	D.O.B.	

Emergency Contact

Last Name:	First Name:	Relationship	Home phone	Work phone	Cell phone

Patient Employment

Employer Name:		Occupation:	
Address	City	State	Zip

Questions

Who referred you to us?		
How did you hear about our clinic?		
Are you here because you were involved in a vehicle collision?	☐ Yes	☐ No
Are you here because you were injured at you place of employment?	☐ Yes	☐ No
Are you here because you were involved in another type of accident?	☐ Yes	☐ No
Will you be using health insurance to supplement payment to our office?	☐ Yes	☐ No

Insurance Coverage

Primary Insurance Company	Primary Ins. ID#	Group #
Secondary Insurance Company	Secondary Ins. ID#	Group #

I understand and agree to the following:

My case may not be accepted for treatment at this clinic.
If the doctors believe that I may respond to their care, additional services may be recommended and I will be advised of applicable costs.
There is no guarantee that my health insurance will pay for all or any part of my care.
As the patient or guardian of a patient, I am ultimately responsible for all charges incurred for services rendered.
All payments are due at the time services are rendered.

____
Patient or Guardian Signature

____
Date

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Insured's Information

Last Name:			First Name:			M.I.
Street			City		State	Zip
Employer	Age	D.O.B.	S.S.N.		Gender	☐ Male ☐ Female

Relationship to Patient
☐ Self ☐ Spouse ☐ Dependent ☐ Other ______________________________

Benefits Assignment & Information Release

I authorize the payment of charges be made directly to the doctor(s) of this clinic. This authorization includes:

1. All insurance reimbursement for services rendered, including those which may be payable to me under my insurance plan or policy
2. Amounts owed on my behalf from proceeds of any settlement related to my case.

____
Patient or guardian signature

I authorize the release of any necessary information to my insurance companies, pre-paid health plan or account, or government managed health plan to request payment benefits to me or my assignee.

______________________________ ______________________________
Patient or guardian signature Date

OFFICE USE ONLY:
Insurance Verification

Patient: File# D.O.B.

Person's name that you spoke to?
Last: First:
ID# ______________ Extension: ______________.

Does the plan have a deductible? Yes No

Amount for an individual: ______________
Amount for the family: ______________
Amount currently met: ______________

After deductible, what % of services do you cover? ______________

When does the deductible renew? ______________

Does the patient have a co-pay? Yes No

Amount for the co-pay: ______________

What is the max. yearly benefit? ______________

Does the company assign benefits to the doctor? Yes No

What is the yearly visit cap? ______________

Are any special forms required to file claims? Yes No

Auto Collision or Personal Injury case? Yes No

Reported to the insurance company? Yes No

Already filed an application for benefits? Yes No

Did the police write a report? Yes No

Is auto or PI insurance primary? Yes No

Agent name and contact info: ______________

Worker's Comp case? Yes No
Has the injury been reported? Yes No

Name:
Title:

Is patient currently employed at place of injury? Yes No

Name of person authorizing care: ______________
____

Does the plan cover the following services?

Chiropractic Adjustments
Modalities by a Chiropractor
X.Rays
☐ Orthotics, supports, pillows and nutritional supplements
☐ Therapeutic Exercise, Activity & Neuro-Muscular Re-education
☐ Other

Address to send claims?