Pinnacle Sports Performance & Rehabilitation

(Please fill out this form in its entirety)

Name: (First) _____ (Middle Initial) ____ (Last) _____ Date of Birth: _____

Address: _____City: _____ State: _____ Zip Code: _____

SSN #:_____ Driver's License #/State:_____ Marital Status: S M D W

Phone: (Home) _____ (Work)_____ (Cell)_____ Gender: M F

Email Address:_____ Employer: _____

Address:_____ City: _____ State: ___ Zip:_____ Occupation:_____

Referring Physician:_____ Family Physician/PCP(if different than referring):_____

Who can we thank for this referral?_____ **OR** How did you hear about us? _____

Emergency Contact Name:_____ Relationship:_____ Phone:_____

Primary Insurance Information: **Please provide us with EACH insurance card, so that we may obtain additional information for claims filing.**

Primary Insurance:_____ ID Number:_____ Group Number:_____

Name of Policy Holder:_____ Policy Holder DOB:_____ Policy Holder SSN:_____

Policy Holder Employer:_____ Is Policy Through Employer? Yes___ No___ Relationship to Patient:_____

Secondary Insurance Information: ☐ **I Do Not Have Secondary Insurance**

Secondary Insurance:_____ ID Number:_____ Group Number:_____

Name of Policy Holder:_____ Policy Holder DOB:_____ Policy Holder SSN:_____

Policy Holder Employer:_____ Is Policy Through Employer? Yes___ No___ Relationship to Patient:_____

Accident or Injury? Yes No Date of accident/injury: _____/_____/_____ ☐ Workers Comp ☐ Auto Accident ☐ Slip & Fall ☐ Other

Do you have an attorney? Yes No Name:_____ Phone Number:_____

Workers Comp Insurance Carrier:_____ Claim #:_____

Adjuster Name:_____ Phone Number:_____ Employer:_____

Consent to Treat: I consent to all examination procedures and/or treatments prescribed by my chiropractor, Dr. Michael A. Bhatt as is necessary in his judgment.

Assignment of Benefits: I hereby assign, transfer, and set over to Dr. Michael A. Bhatt/Pinnacle Sports Performance all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy/personal injury protection benefit. In the event that I receive any insurance payments directly, I realize that I will be billed personally until this balance is paid in full.

This authorization shall remain valid until written notice is given by me revoking said authorization. A photocopy of this authorization is to be considered as valid as the original.

_____ _____ _____

Responsible Party Signature **Date** **Relationship to Patient**