Brighton Campus Chiropractors, L.L.C.

Dr. Louis Catapano, Dr. John Sciortino, Dr. Christine Sanewsky
2024 W. Henrietta Road, Suite 5B
Rochester, NY 14623
(585) 272-7340

The following information is necessary for our files. Please answer all questions completely.

List present complaint (Why are you here today): ____

____

____

On the line provided, please mark where your "pain" is today.

____

0	5	10
No Pain		Most Severe pain

Social Security #: ____

Name: ____

Address: ____

City: ______________________________ State: __________ Zip: ____________________

Home Phone Number: ______________________

Employer: ____

Employer's Address: ____

City: ______________________________ State: __________ Zip: ____________________

Work Phone Number: ______________________

Occupation: ____

Age: ____________ Date of Birth: ____________ Marital Status: ______________________

Spouse's Name: ______________________________

In an Emergency, who may we contact: ______________________ **Phone#:** ______________

DO YOU HAVE HEALTH INSURANCE? Yes____ No ____ PLEASE GIVE THE RECEPTIONIST YOUR INSURANCE CARD.

Insurance Company Name: ______________________ Contract #: ______________________

Who is your Primary Care Physician? ____

FEMALES ONLY: Who is your OB/GYN Physician? ______________________________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________________

IF RADIO, WHICH STATION? ______________________

E-MAIL ADDRESS? ____________________________________

I clearly understand and I agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care any fees for professional services rendered me will be immediately due and payable. If I have an insurance carrier, I understand that I am responsible for any deductible, any portion of the fee the carrier does not pay for, or if there is an unreasonable delay by the carrier or myself, I will be responsible for payment on request by this office. If this account is turned over to a lawyer, collection agency, or to the courts, I further agree to be responsible for the payment of all courts to this office for collection of services, including attorney fees, and the amount due is subject to the highest interest possible in this state.

Patient Name (Print): ______________________________ **Date:** ______________

Patient Signature: ______________________________

Parent/Guardian Signature: ______________________________