



PATIENT INFORMATION

First Name _____ (MI) _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Age ____ Birth date _____ Social Security# _____ Sex _____

Occupation _____ Employer _____

Marital Status (S M D W) Spouse's name _____

Employer _____ Phone _____

Email Address _____ Referred By _____

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Current Complaints _____

Date Symptoms appeared _____ Have you ever had same condition? Y / N

If yes when? _____ Have you ever been under chiropractic care? Y / N

List other practitioners seen for this condition _____

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INSURANCE INFORMATION:

Name of Insured _____ Insurance Co. name _____

Address _____ Phone# _____

ID# _____ Group# _____

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I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature _____ Date _____