

ID # _____ Date _____

Name _____ Birth Date _____

Address _____ City/State _____ Zip _____

Phone / Home _____ Cell _____ Work _____

E-Mail Address _____

Employed / Student / Retired _____ Employer / School Name _____

Marital Status _____ Spouse's Name _____

Insurance _____

Self / Spouse / Parent _____ Date of Birth of Insured (If Other than Patient) _____

Name of Insured (If Other than Patient) _____

Insured's Employer (If Other than Patient) _____

Who Referred You to Us? _____

Past Chiropractic Care? Yes / No Dr.'s Name / Location _____

_____ Last Visit _____

Current Medical Care? Yes / No Why? _____

Current Drugs / Medication _____

Reason for Consulting this Office _____

Please check the one choice that most closely describes your current goals for health / wellbeing.

I am only concerned about relief of a particular symptom.

I am only concerned about relief of a particular symptom, and preventing its return.

I want optimum health and wellbeing on every level available to me.

WE ACCEPT PAYMENT BY CASH, CHECK, AND CREDIT CARD.

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing.

Signature _____ Date _____