ID #_____ Date_____

Name_____ Birth Date_____

Address_____

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 _____