NEW PATIENT INFORMATION

Date:________________________

Name:__________________________________ Address:______________________________________

City/State/Zip:______________________________________ Home Phone:________________________

Social Security#:_______________________ Birthdate:________________ Male:_____ Female:_____

Spouse Name (or Parent):___________________ E-Mail Address:___________________________

Status: Married_____ Single_____ Divorced_____ Widowed_____# of Children _________________

Occupation: ___________________________ Employer: ______________________________________

Work Phone#: ____________________________ Cell Phone#:_______________________________

How were you referred to our office? ____Friend/Family ___Yellow Pages ____Newspaper Ad
____Other, please explain____

Who may we thank for referring you? ____

Have you ever had Chiropractic care before? __________ If so, when?___________________________

(A). Is this condition work-related? _____ If so, has the injury been reported to your employer? _____

Has your employer authorized treatment at this office? _________

(B). Is this condition related to an auto accident? ______ Has the accident been reported to your

insurance carrier?______ Name of insurance company:______________________________

Date of accident: ___________________ Claim Number: ______________________________

List any hobbies and/or athletic activities that you do: ____

____ How often? ______________________________

NOTICE: If your examination warrants an x-ray, the fees paid for this service are for analysis only. The films are the property of this office. We are required by law to keep films on file for seven years. If you need the films for review by another professional a signed release is required and the films must be returned to our office within thirty (30) days.

Method of payment you plan to use to take care of today's charges:

Cash ________ Check ________ Credit Card ________