



CHIROPRACTIC



CARE IS A



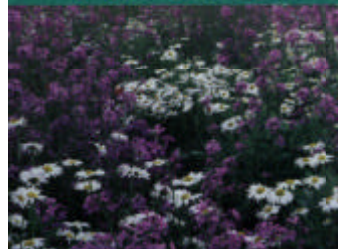
NATURAL



RESOURCE



FOR YOUR



GOOD HEALTH



WELCOME

CONFIDENTIAL

Patient Information

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Date _____ Patient No. _____ S/S _____
First MI Last

Address _____ City _____ State _____ Zip _____

Sex: Female Male

Birth date _____ Home phone # _____ Work phone # _____

Do you prefer to receive calls at: Home Work Either

Are you: Minor Married Divorced Widowed Single Separated

Your employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's or parent's name _____ Workplace _____ Work phone # _____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account? _____ S/S _____

Relationship to patient _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Name of employer _____ Work phone # _____

Insurance Information

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Phone # () _____ - _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

DO YOU HAVE ADDITIONAL INSURANCE? No Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured _____ Relationship to patient _____

Birth date _____ Social Security # _____ Date employed _____

Name of employer _____ Work phone # _____

Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____



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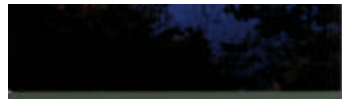
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How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

