Patient Information

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

(Please Print)

Name____**Date**_______________**SS#**__________________________

First **Middle Initial** **Last**

Address____**City**_________________**State**___________**Zip**_______

Sex: ☐ **Female** ☐ **Male** **Birthdate**_____________________**E-Mail**____

Home Phone (_______**)** ___________________**Cell Phone (**_______**)** ___________________**Work Phone (**______**)** ____________________

Do you prefer calls at: ____**Home** ____**Work** ____**Cell** ____**No Preference**

____**Married** ____**Widowed** ____**Single** ____**Minor** ____**Separated** ____**Divorced**

Patient Employer/School____**Occupation**____________________________________

Employer/School Address____**City**_______________**State**____________**Zip**__________

Spouse or Parent'sName________________________________**Employer**___________________**Work Phone (**______**)** _______________

Who may we thank for referring you to us? ____

Person to contact in case of emergency ____**Phone (**_____**)** ______________________

Responsible Party/Insurance Information

Name of Insured _____________________________________**Relationship to patient** ____

Birthdate ________________________________**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 deductable? _______________________**How much have you used?** _____________**Max annual benefit?** ___________

DO YOU HAVE ADDITIONAL/SECONDARY HEALTH INSURANCE? ____**No** ____**Yes** **IF YES, COMPLETE THE FOLLOWING:**

Name of Insured ____**Relationship to patient** ____________________________________

Birthdate ____________________________________**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 deductable? _________________________ **How much have you used?** _______________ **Max annual benefit?**__________