Confidential Practice Member Information

Welcome. This information is important, please print clearly. Date:

Name:______________________________________ **Email:**________________________________

Social Security #:_______________________________________

Home #:________________________ **Cell #:**__________________________ **Work #:**________________________

Address:____

City:____ **State:**_______ **Zip:**_________________________________

Birth Date:____________________________ **Age:**________ **Sex:** M F **Marital Status:** S M W D

Occupation: _________________________________ **Employer:** _________________________________

Children:____

Who referred you to our office?____

May we leave personal medical information on your answering machine at home or on your cell phone voicemail? Yes No

Do you give our office permission to discuss your medical information with family members? Yes No (if yes, please provide their names and phone numbers below)

Name: ____**Relationship:**___________________________________
Phone #:_______________________________________

Have you ever been to a chiropractor before?_________________ **If so, when?**____________________________

Describe your symptoms, if any, and how have they affected your life?

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Are you currently under a doctor's care?____

If this is work related, have you reported it to your employer? Yes No N/A

Is this related to an auto accident? Yes No **Date of accident:**______________________________________

Shoe Size________ **Females: Are you pregnant?** Yes No Not Sure

If the doctor determines that services are necessary, all charges are payable when rendered.

What form of payment will you use? Cash_______ Check____________ MC/Visa__________

If you have insurance that covers chiropractic care, we can assist you in filing your claims.