

# WELCOME

## Natural Healing Through Chiropractic Care

### 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 \_\_\_\_\_ 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 \_\_\_\_\_

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