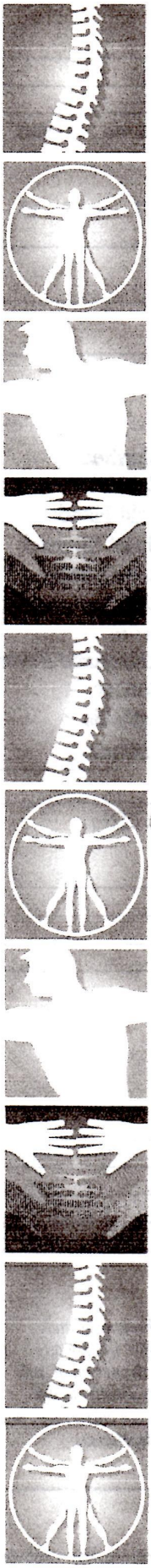

WELCOME

HELP YOUR BODY HEAL ITSELF WITH CHIROPRACTIC

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 # _____

How many children?___Email Address_____

Previous Chiropractor No___ Yes___ Who_____

RESPONSIBLE PARTY

Name of person responsible for this account:_____

CONFIDENTIAL