ACCT#_____

WELCOME TO OUR OFFICE! DATE:_____

Name _____ Home Phone _____

Address _____City/State/Zip _____

Age _____ Birth Date ____/____/____ Martial Status: S M W D No of Children _____Name of Spouse_____

Email Address _____ Cell phone _____

Social Security Number _____ Driver License Number _____

Occupation _____ Employer _____

Address _____ Office Phone _____

Who should we contact in case of Emergency? _____ Phone number _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

Have you ever suffered from:	YES	NO		YES	NO
1. Headaches	____	____	8. High Blood Pressure	____	____
2. Neck Pain	____	____	9. Diabetes	____	____
3. Backaches	____	____	10. Digestive Disorders	____	____
4. Arm Pain/Numbness	____	____	11. Nervousness	____	____
5. Leg Pain/ Numbness	____	____	12. Sinus Trouble	____	____
6. Arthritis	____	____	13. Asthma	____	____
7. Dizziness	____	____	14. Cancer	____	____

Have you been treated for any other health condition by a physician in the last year?_____

Reason for this Appointment: _____

Have you seen a chiropractor for this or any other condition? _____ If so, when was your last visit? _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT! Will you be paying today by: Cash Check Credit Card

Are you Insured? YES NO Insurance Co: _____ Phone Number_____

Primary Insured's Name _____DOB:____/____/____ Relationship: Self Spouse Child Other

Subscriber ID _____ Group # _____ Employer _____

Auto or Work Injury? YES NO If yes, do you have an attorney? Name_____(____)_____

I understand and agree that health and accident insurance policies are an arrangement between insurance carrier and myself. Furthermore, I understand that FAMILY CHIROPRACTIC CENTER will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to FAMILY CHIROPRACTIC CENTER will be credited to my account upon receipt. However, I clearly understand and agree that any services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment. Any fees for professional services rendered me will be immediately due and payable.

_____ _____

Patient Signature or Parent/Legal Guardian Date