Patient Information

Pain Relief CHIROPRACTIC

* Denotes required information

ABOUT YOU

Today' Date ______/______/______ *Sex ☐Male ☐Female Patient Number_____________

PATIENT

*FULL LEGAL NAME – First________________________________ M.I.__________ Last____________________________________

Prefer to be called____ Social Security # ___________ - ________ - ____________

Email Address (please write legibly)____

*Date of Birth (MM/DD/YY) _____/_____/_____ Age____ Marital Status ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

*Street Address ____

*City ____ *State ___________ *Zip code _________________________

*Phone: Cell (_____) ____________________ Home /Alternate (_____)____________________

How were you referred to us / by whom? ____

Privacy Statement Received? ☐Yes - Date _____/_____/_____ ☐No

EMPLOYMENT

Employer ____ Occupation ___________________________________

Employer's Address __________________________________City_____________________________St______ Zip____________

Work Phone (_____) ____________________ Employment Status ☐Full time ☐Part time ☐Not employed ☐Retired ☐Military

***PARENT / GUARDIAN** (if patient under 18)*

NAME – First____ M.I._________ Last____________________________________

What is your relationship to the patient?____

Email Address (please write legibly)____

*Street Address ____

*City ____ *State ___________ *Zip code _________________________

*PHONE: Cell (_____) ____________________ Home /Alternate (_____)____________________

INSURANCE INFO ** *NOTE::* **Let us copy your current insurance card(s) and you will not need to fill out this insurance section.**

***Primary** Insurance Co. Name ____ Phone # (_____)________________________

*Insurance ID _______________________________________ Group/Policy # ____

*Insurance Address ______________________________________*City_________________________*St_____*Zip__________

*Insured's Name (if different than patient)___________________________________Insured's SS#____________________________

*Insured's Address_______________________________________*City_________________________*St_____*Zip__________

*Insured's Phone # (_____)_________________ Sex ☐Male ☐Female

Relation to Insured____ *Date of Birth ______/______/______ Age________

***Secondary** Insurance Co. Name ____ Phone # (_____)________________________

*Insurance ID _______________________________________ Group/Policy # ____

*Insurance Address _____________________________________*City_________________________*St_____*Zip__________