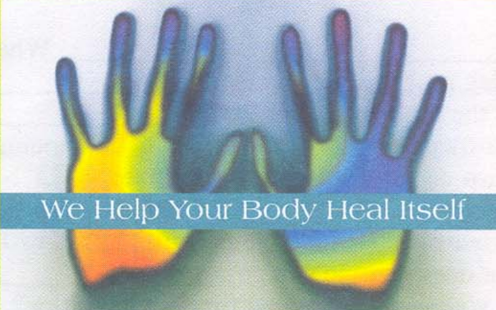
WELCOME



OPTIMUM HEALTH 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 ________ SS/HIC/Patient ID#__________
First Middle Initial Last

Address ______________________ City ______________ State _____ Zip ________

Sex: ❑ Female ❑ Male Birthdate ____________ E-mail ____________________

Home Phone (_____)__________ Cell Phone (_____)__________ Work Phone (_____)__________

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for_____years

Patient Employer/School __________________________ Occupation ______________

Employer/School Address ______________________ City __________ State ____ Zip ______

Spouse or parent's name ________________ Employer __________ 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 ______________________________

Relationship to patient ______________________ Phone (_____)__________

Address ______________________ City ____________ State _____ Zip ______

Name of employer ______________________ Work Phone (_____) __________

Insurance Information

Name of insured ______________________ Relationship to patient ______________

Birthdate ______________ 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 ______________

Birthdate ______________ 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? ________

CONFIDENTIAL

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