

NAME

#

DATE

PERSONAL INFORMATION

LEGAL NAME _____

WHAT DO YOU PREFER TO BE CALLED? _____

ADDRESS _____

CITY _____ ST _____ ZIP _____

HOME PHONE # _____

WORK PHONE # _____

CELL PHONE # _____

DATE OF BIRTH _____ AGE _____

___ MALE ___ FEMALE

SS # _____

DRIVERS LICENSE # _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

MARITAL STATUS (circle one) M S D W

SPOUSE'S NAME _____

SPOUSE'S SS # _____

WHOM MAY WE THANK FOR REFERRING YOU TO

OUR OFFICE? _____

IN THE EVENT OF AN EMERGENCY

WHO SHOULD WE CONTACT?

NAME _____

RELATION _____

HOME PHONE _____

ALTERNATE PHONE _____

OUR OFFICE POLICY REQUIRES PAYMENT IN FULL FOR ALL SERVICES RENDERED AT THE TIME OF VISIT, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE BUSINESS MANAGER. I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM IS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS. I HEREBY CONSENT TO TREATMENT.

SIGNATURE _____

WELCOME

TYPE OF INSURANCE (circle one)

PPO/GROUP - MEDICARE - AUTO - WORKER'S COMP - CASH

INSURANCE NAME _____

ACCOUNT INFORMATION (if different than patient)

INSURED'S NAME _____

RELATIONSHIP _____

BILLING ADD. (if different) _____

CITY _____ ST _____ ZIP _____

HOME PHONE (if different) _____

WORK PHONE # _____

DATE OF BIRTH _____

SS # _____

DRIVERS LICENSE # _____

EMPLOYER _____

EMPLOYER'S ADDRESS _____

CONSENT TO TREAT A MINOR

I HEREBY AUTHORIZE DR. MARTIN TO ADMINISTER CHIROPRACTIC CARE AS WELL AS ANY THERAPIES DEEMED NECESSARY TO MY CHILD OR GUARDIANSHIP.

CHILD'S NAME _____

SIGNATURE (PARENT OR GUARDIAN) _____

DATE _____

DATE _____