RECOVERED
CHIROPRACTIC

Welcome to Our Office

Thank you for choosing our practice for your chiropractic and massage needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PLEASE PRINT

PATIENT INFORMATION

Name: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Marital Status: _____ Number of Children : _____

Email Address: _____ Occupation: _____ Employer: _____

Spouse's Name: _____ Spouse's Employer: _____

Who can we thank for referring you to our office? _____

PHONE NUMBERS

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Best Time And Place To Reach You Is:

_____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Home Phone: _____

Cell Phone: _____

INSURANCE INFO

Do you have health care insurance? ☐ Yes ☐ No Insurance Company: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____

Is patient covered by additional insurance? ☐ Yes ☐ No If yes, please complete the following:

Insurance Company: _____ Subscriber's Name : _____

Subscriber's Date of Birth: _____ Relationship to Patient: _____

ACCIDENT INFORMATION

Are you here due to an: ☐ Auto Accident ☐ On the Job Injury ☐ Other Accident: _____

If yes, please complete the following: Date of Accident: _____

To whom have you reported the accident: ☐ Auto Ins. ☐ Workers Comp ☐ Other: _____

Insurance Company: _____ Claim Number: _____