Case #: ____________

Back to Wellness Chiropractic
PATIENT INFORMATION SHEET

PLEASE FILL IN THE APPROPRIATE SPACES (All information is confidential)

PATIENT INFORMATION:

Last Name: ______________________________ First Name: ____________________ Today's Date: ________________

Patient's Date of Birth: __________________ Social Security Number: ______ / _______ / _______

What you prefer to be called: ________________ Age: _____ Sex: _____ Drivers License #: ___________________

Home Address: ____ City______________________ Zip Code_________

Home phone #: ___________________ Work phone #: ____________________ Cell phone #: ____________________

E-mail address: ____

Who may we thank for referring you? ____

Employer: ____ How long? ______________________________

Employer's Address: ____

Occupation: ____ Status: Married / Divorced / Single / Widowed

Spouse's Name: _________________________________ Spouse's Occupation: _______________________________

Do you have children? Yes / No How many? _______________

EMERGENCY: Contact information for nearest relative or friend.

Who should we contact? ____ Relation: ___________________________

Home phone #: ___________________ Work phone #: ____________________ Cell phone #: ____________________

PAYMENT METHOD: ☐ Cash ☐ Check ☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

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INSURANCE: If you have insurance please give your card to the office manager to be copied.

Insurance Company: ____ Phone: _________________________

Policy #: ____________________________ Group #: _____________________ Contract #: ______________________

RESPONSIBLE PARTY: Complete this section if you are not the patient but are responsible for payment.

Responsible Party: _______________________________________ Relationship to Patient: _______________________

Home Address: ____ City______________________ Zip Code _________

Home phone #: ___________________ Work phone #: ____________________ Cell phone #: ____________________

Employer Name: __________________ Occupation? _________________ DOB: __________ SS#: _____/____/_____

Employer's Address: ____________________________________ City ______________________ Zip Code ________

REASON for this visit: ____ Date of injury__________

Work related accident? ☐ **Yes** ☐ **No** Auto Accident? ☐ **Yes** ☐ **No** Other Accident? ☐ **Yes** ☐ **No**