Confidential New Patient Form

(Please print)

Full Legal Name: ____ Date of Birth: ____________________

Street Address: ____ Home Phone: ____________________

City/State/Zip: ____ Work Phone: ____________________

Social Security Number: _____________________________________ Cell Phone: ____________________

Employer: ____ Job Title: _______________________

Employer Address: ____

Marital Status (circle one): Married Single Widowed Divorced Email: __________________________

Name/ages of children: ____

Spouse's Name: ______________________ Spouse's DOB: ___________ Spouse's SSN: _________________

Spouse Occupation: _____________________ Spouse Employer: _____________________________________

Names of family members being treated at our clinic:____

Emergency Contact Name: ____________________ Relationship: ______________ Phone: _____________

Who referred you to our office? ____

Please circle the type of care you desire: Temporary relief Long term corrective Doctor recommendation

Gender* (circle one): Male Female Preferred language: ______________

Ethnicity* (circle one): Hispanic/Latino Non Hispanic/Latino I decline to answer

Race* (circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I decline to answer

Smoking Status* (circle one): Every day smoker / Occasional smoker / Former smoker / Never smoked

Smoking Start Date (Optional): ______________________________

Preferred method of communication for patient reminders: Email / Phone / Mail

☐ **I choose to decline receipt of my clinical summary after each visit.** (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Agreement	ASSIGNMENT AND RELEASE I, the undersigned, have insurance coverage with ____ Name of Insurance Company And assign directly to Dr. ______________________ all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. _________________________________ _________________________________ Signature of Insured/Guardian Date

For office use only

Height: ______________________________ **Weight:** _________________ **Blood Pressure:** _____/_____

*Required per Federal Guidelines