ADVANCED CHIROPRACTIC WELLNESS CENTER

CONFIDENTIAL PATIENT INFORMATION

Please Tell Us

Who Referred You: _____

Name: _____

Date of Birth: MM / DD / YY **Age:** _____ **Sex**: **M** ☐ **F** ☐

Mailing Address: _____

_____

Phone: **(H)** _____ **(C)** _____ **(W)** _____

Email: _____

Occupation: _____

Employer Name: _____

Emergency Contact: Name: _____

Relationship: _____ Contact Number: _____

Insurance? ☐ **Self Pay?** ☐

Insurance Company: _____

Insured Name: _____

Relationship to Patient: _____

Certificate/ID No.: _____ **Policy/Group No.:** _____

By signing below, I certify that all the information above is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges incurred if not covered or paid by insurance.

Patient Signature: _____ **Date:** _____