Patient Demographics

Today's Date / /

First Name_____ **Nick Name**_____

Last Name _____ **Middle Name** _____ **Suffix** _____

Address 1 _____

City_____ **State**_____ **Zip Code** _____

Mobile Phone _____ **Secondary Phone** _____

Home email _____ **Work Email** _____

By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

Date of Birth / / **Age** _____ **Gender ❑ Male ❑ Female**

How did you hear about our office? ❑ Google Search ❑ Driving by the office ❑ Friend: _____

Contact Method *(check one)* ❑ Mobile Phone ❑ Secondary Phone ❑ Home Email ❑ Work Email

Number Of Biological Children & Ages _____ **Pregnant/Could be?** _____

Marital Status *(check one)* ❑ Single ❑ Married ❑ Other **Partner's Name** _____

Emergency Contact _____ **Phone**_____ **Relation**_____

Employment Status *(check one)* ❑ Employed ❑ Student ❑ Retired ❑ Self Employed ❑ Other

What brings you to our office today? List your main complaints in order of severity:

1._____ **For how long?** _____

2._____ **For how long?** _____

3._____ **For how long?** _____

Is this related to a work injury or auto accident? _____

Do you have any type of Health Insurance? _____ **Company?** _____

Policy # _____ **Policy Holder's Date of Birth** _____

Have you had an X-ray or CT scan or MRI of your low back spine in the past 30 days? ❑ Yes ❑ No

Notice: *All new patients require an examination prior to treatment to properly document the necessity of care and to determine the appropriate treatment. Payment for services is expected at time of service. We will do our best to determine your health insurance benefits, but* ***ultimately you are responsible for knowing your insurance benefits prior to treatment.*** *By signing this form, you agree that you are responsible for payment regardless of your insurance coverage. Should you have questions about your insurance coverage, you agree to discuss with office staff prior to services being rendered.*

Signature of Patient _____ **Date** _____