FAIRVIEW PARK CHIROPRACTIC CENTER

WELCOME

PLEASE FILL OUT ALL INFORMATION BELOW

TODAY'S DATE ____________________ S.S. # ___________________________

NAME ____________________________________ SEX _____ AGE __________

HOME PH# ____________________ CELL/WORK PH# _______________________

E-MAIL (FOR NEWSLETTERS AND INFO.) _________________________________

ADDRESS ____

CITY _________________________ STATE ____________ ZIP CODE _________

BIRTHDATE _________________ MARITAL STATUS M S W D (CIRCLE ONE)

HOW MANY CHILDREN DO YOU HAVE? ________ (WE TREAT YOUNG KIDS TOO!)

EMPLOYER _____________________________ OCCUPATION ________________

EMPLOYER'S ADDRESS ____

NAME OF SPOUSE__________________ SPOUSE'S OCCUPATION ____________

WHOM SHALL WE NOTIFY IN CASE OF AN EMERGENCY? __________________

PH# OF PERSON TO NOTIFY ____

WE TRULY APPRECIATE REFERRALS TO OUR OFFICE! WHOM MAY WE

THANK FOR REFERRING YOU? ____

HOW DID YOU HEAR ABOUT US? _______________________________________

PAYMENTS AND CO-PAYMENTS ARE EXPECTED AT TIME OF SERVICE

IF YOUR ACCOUNT WOULD BECOME DELIQUENT AND COLLECTION PROCEDURES ARE NECESSARY TO COLLECT, A $36 COLLECTION CHARGE WILL BE ASSESSED.

NAME OF PERSON RESPONSIBLE FOR PAYMENT __________________________

PATIENT'S SIGNATURE ____

GUARDIAN'S SIGNATURE (IF PATIENT IS A MINOR) ___________________________________