Ranch Chiropractic

PATIENT INFORMATION

Date: _____

Patient Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Birthdate: _____/_____/_____ Age: _____

Marital Status: S M D W Sex: M F

Occupation: _____

Employer: _____

Spouses Name: _____

Name & Location of Your Primary Care Physician: _____

CONTACT INFORMATION

Home #:(_____) _____-_____

Work #:(_____) _____-_____

Cell #:(_____) _____-_____

E-mail: _____

Best Time to reach you: _____

I give Ranch Chiropractic permission to communicate with me. Initial: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____

Relation: _____

Best #: _____

HOW DID YOU HEAR ABOUT US?

Personal Referral:_____

Internet Web Address:_____

Our location:_____

Other:_____

INSURANCE

Payment is due at the time of service. As a courtesy we will supply you with a super bill that you can submit to your insurance company for reimbursement. (Excludes Kaiser, Personal Injury, Medicare and Medicaid)

People seek chiropractic care for a variety of reasons. Some are interested in symptomatic relief of pain or discomfort (relief care), others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved (corrective care).

Please check the type of care desired:

- ☐ Relief care
- ☐ Corrective care
- ☐ Check here if you want the Doctor to select the type of care appropriate for your condition