

For office use only

Patient Number: \_\_\_\_\_

Insurance  Scanned

Date: \_\_\_\_\_

## NEW PATIENT INTRODUCTION CARD

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_ Secondary/Cell: \_\_\_\_\_

Email: \_\_\_\_\_

Permission to send office related emails:  Yes  No      Chiropractic related emails:  Yes  No

(Office related emails include offers, office closures, and special offers. Chiropractic emails will be a series of informational messages related to your injury or chiropractic in general.)

Marital Status: \_\_\_\_\_ #of Children: \_\_\_\_\_ Their ages: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Physical job requirements: \_\_\_\_\_

Previous Chiropractic Care:  Yes  No      Chiropractor's Name: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ May we contact them?  Yes  No

*Please Provide Insurance Card to be scanned.*

Insurance Company: \_\_\_\_\_

Insured First Name: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_ Insured Date of Birth: \_\_\_/\_\_\_/\_\_\_

Major Complaint: \_\_\_\_\_

Is pain stopping you from participating in any daily or recreational activities?  Yes  No

If Yes, explain: \_\_\_\_\_

Are you sleeping well?  Yes  No      Are you always tired?  Yes  No

Are you having any digestive issues/concerns:  Yes  No

If Yes, explain: \_\_\_\_\_

Are there any concerns you have about starting Chiropractic care or about your current health? \_\_\_\_\_

How did you find out about us?       Friend/Family: \_\_\_\_\_       Office Sign

Facebook       Web search       Instagram       Other: \_\_\_\_\_

*It is usual and customary to pay for services as rendered unless otherwise arranged*