New Patient Form

Name	
Date of Birth	
Email	
Chief Complaint	❑ Neck ❑ Back ❑ Headaches ❑ Other:_____

Your email will NOT be shared with any 3rd parties, and is used for general office announcements and promotions.

Address			
City/State/Zip	City:	State:	Zip:
Mobile Phone			
Other Phone	Home:	Work:	

Occupation		**Employer**	

	Name	**Phone**
Emergency Contact		
Primary Physician		

Referral	❑Internet ❑ Sign ❑ Flyer/Mail ❑ By: _____

Preferred Payment:

❑ Cash

❑ Insurance: Carrier _____ Phone _____

ID#: _____ Group ID: _____ SS#:_____

Although chiropractic has an excellent safety record, no health treatment is completely free of potential adverse effects. The risks associated with chiropractic, however, are very small. Any minor discomfort or soreness following spinal manipulation typically fades within 24 hours. **By signing this form, you acknowledge that you have read, understood, and agree with the Informed Consent to Chiropractic Treatment.**

Signature _____ **Date** _____