Core Chiropractic & Wellness
Chiropractic Center

PATIENT INFORMATION

NAME: S.S#: SEX: M ☐ F ☐

ADDRESS:

CITY: STATE: ZIP:

HOME PHONE: CELL PHONE:

EMAIL ADDRESS:

DATE OF BIRTH: AGE: MARITAL STATUS: S ☐ M ☐ D ☐ W ☐

How do you prefer to be contacted: ☐ home phone ☐ cell phone ☐ text ☐ email ☐ other

EMPLOYMENT INFORMATION

EMPLOYER: PHONE:

ADDRESS: CITY: STATE: ZIP:

OCCUPATION/DUTIES:

FAMILY INFORMATION

SPOUSE OR PARENT: CONTACT #:

NEAREST RELATIVE NOT LIVING WITH YOU: CONTACT #:

FAMILY PHYSICIAN: CONTACT #:

EMERGENCY CONTACT: CONTACT #:

INSURANCE INFORMATION ** (IF NO CARD PROVIDED)**

NAME OF RESPONSIBLE PARTY

INSURANCE PROVIDER:

ADDRESS: CITY: STATE: ZIP:

PHONE: POLICY/ID # GROUP#

DO YOU HAVE A SECONDARY INSURACE? ☐ YES ☐ NO

Welcome! Thanks for choosing CORE CHIROPRACTIC & WELLNESS

HOW DID YOU HEAR ABOUT US? REFERRAL Y ☐ N ☐ WHO?

YELLOW PAGE: Y ☐ N ☐ OTHER?

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Dr. Kessa Tucker to release my records to my insurance company or any other party for settlement of my claim.

Patient's signature _____ Date _____

Spouse's or guardian's signature _____ Date _____