

# WELCOME TO DYNAMIC CHIROPRACTIC

Please complete all of the following New Patient Information.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_  
MARITAL STATUS:  
\_\_\_\_ MARRIED      \_\_\_\_ DIVORCED      \_\_\_\_ SINGLE      \_\_\_\_ OTHER  
EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
SPOUSES NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_  
CHILDREN'S NAMES AND AGES: \_\_\_\_\_  
WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

• **CURRENT HEALTH COMPLAINTS/REASONS FOR CONSULTING THIS OFFICE:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Have you had similar problems before? \_\_\_\_\_

If so, for how long? \_\_\_\_\_

Is this a result of an auto or work accident? Y N      Date of accident: \_\_\_\_\_

Do you have other family members with similar problems? Y N

Other Dr.'s seen for this problem? \_\_\_\_\_

Previous surgeries: \_\_\_\_\_

Medications you currently take? \_\_\_\_\_

Is there a chance you may be pregnant (females only)? \_\_\_\_\_

Have you ever been diagnosed with cancer? Y N      If so, what type? \_\_\_\_\_

Do have health insurance? Y N      Name of company: \_\_\_\_\_

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the doctor. If account is not paid within 90 days, you will be responsible for legal fees, collection fees and any other costs incurred with collecting your account.

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