CORE CHIROPRACTIC

149 Iron Point Road ~ Folsom, CA 95630
916-989-1014

PATIENT # ____________

Date:____________________

First Name ______________________ **M.I.**____ **Last Name** ____________________________

Address ____________________________**City** ________________ **Zip Code** _____________

Date of Birth ______/______/______ **Sex:** Male Female Height: ______Weight _______

Home Phone (_____) _______-___________ **Cell Phone** (_____) ________-______________

Work Phone (_____) _______-___________ **Email** ________________________________

Leave Messages on: (Circle one) Home Cell Work Don't leave messages

Employment Status: Employed Unemployed Other_____

Employer ____

Your Occupation ____

Marital Status: Single Married Other **Student:** Full-time Part-time

<u>Spouse Data:</u>

First Name ______________________ **Middle Initial** ____ **Last Name** _____________________

Home Phone (_____) ______-_________ **Cell Phone** (_____) ______-_____________

Spouse Date of Birth _____/_____/______ **Name of Guardian (if minor)** __________________

<u>Emergency Contact:</u>

Contact Name __________________________ **Relationship to Patient** ____________________

Contact: Home Phone (_____) ______-________ **Cell Phone** (_____) _______-_____________

<u>RESPONSIBLE PARTY for payment:</u> ______________________ **<u>PHONE</u> #** ________________

Please present your insurance card(s) for us to copy (with Medicare - also your secondary insurance).

Does your insurance company contribute to Chiropractic care? ☐ **Yes** ☐ **No**

Who may we thank for referring you to us? ____

Patient Signature__________________________________ **Date:**____________________

Parent/Guardian Signature__________________________ **Date:**____________________