



FINNELL 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

Spouse Data:

First Name \_\_\_\_\_ Middle Initial \_\_\_\_ Last Name \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Spouse Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Name of Guardian (if minor) \_\_\_\_\_

Emergency Contact:

Contact Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Contact: Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**RESPONSIBLE PARTY for payment:** \_\_\_\_\_ **PHONE #** \_\_\_\_\_

**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:** \_\_\_\_\_