ADIRONDACK REGION

CHIROPRACTIC

GENERAL PATIENT INFORMATION (confidential)

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIPCODE** _____

PHONE: _____ **SOCIAL SECURITY#** _____

EMPLOYER: _____ **WORK PHONE:** _____

DATE OF BIRTH: _____ **SEX: M F**

(MONTH/DAY/YEAR)

MARITAL STATUS: S M D W **NUMBER OF CHILDREN:** _____

MEDICAL DOCTOR: NAME _____ PHONE _____

PREVIOUS CHIROPRACTIC CARE: NAME _____

ADDRESS _____

PHONE _____

INSURANCE INFORMATION:

PRIMARY COMPANY _____

ADDRESS _____

POLICY# _____ PHONE _____

SECONDARY COMPANY _____

ADDRESS _____

POLICY# _____ PHONE _____

HOW DID YOU HEAR ABOUT OUR CLINIC?(you may choose more than one)

BROCHURE BUSINESS CARD FREE TRADER TELEGRAM

BUSINESS SIGN RADIO(WICY)

REFERRAL (NAME) _____

PARENTAL/GUARDIAN CONSENT(CHILDREN 16 YEARS & UNDER)

I give my permission for Dr. Joel T. Santy or Dr. Tracy A. Trudel to perform a thorough history, examination, x-rays if required, and treatment of my child. I understand that this information and the results of the physical examination are strictly confidential.

Name of Parent/Guardian: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____