New Patient Form

☐Mr. ☐Mrs. ☐Miss. ☐Ms. ☐Dr.

First name: _____

Last name: _____

Date of birth: Month: _____ Day: _____ Year: _____

Address: _____

_____

Email: _____

Phone Home: _____ Work: _____ Cell: _____

Occupation: _____

How did you hear about us? _____

Have you been to a chiropractor before? ☐Yes ☐No

Previous Chiropractor's name: _____

Date of last Chiropractic visit: _____

Medical doctor's name: _____

Medical doctor's number: _____

I consent to allow my chiropractor to contact my medical doctor about my health care.

Patient: _____
Signature

Witness: _____
Signature

Financial Agreement

I agree and understand that I am responsible for all charges relating to my visit. I understand that I may be charged a fee of $25 if I cancel an appointment without 24 hours notice, or fail to show up for an appointment.

Date: _____ _____
Signature

Date: _____ _____
Guardian (If patient is under 18 years of age)