



Conscious Chiropractic & Acupuncture

Patient Information

Thank you for choosing our office. In order to serve you properly, we need the following information.

Date _____ Patient Name _____ Patient # _____

SSN _____ Male Female Birthdate _____ Home phone _____

Work phone _____ Cell phone _____ Email address _____

Address _____ City _____ State _____ Zip _____

Check appropriate box: Minor Single Married/Significant other

Employer _____ Occupation _____

Business address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____

Work phone _____ Occupation _____

Whom may we thank for referring you? _____

Please provide us the names of any healthcare providers whom you trust and think we should include in our list for referrals. _____

Person to contact in case of emergency _____ Phone _____

Do you have Medpay as part of your auto insurance policy? Yes No amount? _____

Insurance Information

Name of insured _____ Relationship to patient _____

Is this person currently a patient at our office? Yes No N/A

Birthdate _____ Social Security Number _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Union or local # _____

Ins. co. address _____ City _____ State _____ Zip _____

How much is your deductible? _____ Amount used? _____ Max. annual benefit? _____

Do you have any additional insurance? Yes No

If yes, complete the following:

Name of insured _____ Relationship to patient _____

Birthdate _____ Social Security Number _____ Date employed _____

Name of employer _____ Work phone _____

Address of employer _____ City _____ State _____ Zip _____

Insurance company _____ Group # _____ Union or local # _____