Balance 4 Life Chiropractic

Chiropractic, Nutrition, Fitness, & You

Patient Information

(*Our goal is our patient's care and satisfaction; please complete this form in its entirety, were applicable.*)

Name_____

Date_____

Address_____

City_____ State_____ Zip_____

Home Phone (_____)_____ Status: ☐ Single ☐ Married ☐ Other

Work Phone (_____)_____

Cell phone (_____)_____

Date of Birth_____ Age_____ □ Male □ Female

Email_____ (we send receipts electronically please provide)

Occupation_____Employer_____

Name of Emergency Contact_____

Emergency Contact Telephone#_____

Have you ever received Chiropractic Care? □ Yes □ No

Referred to this office by: □ Friend/Family Member - Name?_____

□ Internet_____ □Other_____

Are you covered by more than one insurance company? ____Yes ____ No