WELCOME

Thank you for choosing Slavik Family Chiropractic for your chiropractic needs. Please complete this form in ink. If you have any question or concerns, do not hesitate to ask for assistance, we will be happy to help.

Patient Information

Full name_____ Date_____
First MI Last

Address_____ City _____ State _____ Zip _____

Apt. # _____ Age:_____ Birth date:_____ Gender: ☐Female ☐Male

Social Security Number_____ E-Mail Address _____

Home phone # _____ Work phone # _____ Cell # _____

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell ☐ Any

Are you: ☐ A minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Your employer _____ Occupation _____

Business address_____ City_____ State_____ Zip_____

Spouse or Parents Name:_____ Workplace_____

Person to contact in case of emergency:_____ Phone#:_____

Insurance Information

Do you have health insurance? ☐ Yes ☐ No

Name of insured:_____ Relationship to patient:_____

Insurance Company:_____

ID/Policy Number: _____ Group Number:_____

Do you have a secondary insurance policy? ☐ Yes_____ ☐ No

Please have your insurance card and your driver's license available for the receptionist to copy

Other Information

Primary care physician:_____ Phone:_____

Date last seen:_____ May we update them on your condition? ☐ Yes ☐ No

Have you seen a chiropractor before? ☐ Yes ☐ No Do you understand what we do? ☐ Yes ☐ No

Who referred you to us? _____

Are we seeing you today as a result of an accident? ☐ Yes ☐ No (If yes, please inform receptionist)

Are you pregnant? ☐ Yes Due Date_____ ☐ No Last Menstrual Period _____

♦ I have provided correct information on the questionnaire to the best of my knowledge. I have also received a copy of this office's Financial Policy and HIPAA Policy. I understand these documents and have had my questions answered. I agree to abide by the terms of these documents for my treatment in this office. ♦

_____ _____

Signature Date