Welcome

Confidential Patient Health Record

Today's Date: _____

PERSONAL INFORMATION

First: _____ M. _____ Last: _____

Date of Birth: _____/_____/_____ Age: _____ Sex: ❑ Male ❑ Female

SS#: _____-_____-_____ Nickname: _____

Martial Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Address: _____

City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ ext. _____

Cell Phone #: _____ Fax #: _____

Email Address: _____

Hobbies: _____

Have You Ever Been to a Chiropractor Before? ❑ Yes ❑ No

If Yes,
Doctor's Name: _____ Date Of Last Visit _____

EMPLOYMENT INFORMATION

Business Name: _____

Work Phone #: _____ Supervisor: _____

Occupation/Job Title: _____

Job Description: _____

_____ I give Marsch Chiropractic Center staff permission to perform necessary services during diagnosis and treatment.

_____ Our office policy requires payment in full at the time of service, unless other advanced arrangement have been made with the office manager. In the event of financial hardship, please make arrangements so that needed care is never missed.

_____ I Acknowledge that I have Received Marsch Chiropractic Center's Notice of Privacy Practices for Protected Health Information.

_____ I would like Marsch Chiropractic Center to notify me of appointment reminders via text and/or email.

_____

Patient Print Name

_____

Patient Signature or Guardian Signature Date