Active Life Chiropractic

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Patient Intake Form

Title ____Dr ____Mr ____Miss ___Mrs ____Ms Gender ___Male ___Female Date _____/ _____/ _____

First Name _____ MI _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ SSN _____-_____-_____

Date of Birth _____ / _____ / _____ Age _____

Race (circle one) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White Other Declined

Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino Declined

Preferred Language English Spanish Other_____

Marital Status Married Single Divorced Widowed Other_____

Employment Status Employed FT/ PT Student FT/PT Retired Homemaker Unemployed Disabled

Employer Name_____

Address _____ **City** _____ **State** _____ **Zip** _____

Job Title _____

PAYMENT AND INSURANCE INFORMATION

Will you be using any of the following? (Circle One)

Insurance Self-Pay Worker's Compensation Personal Injury/Auto Other _____

Primary Insurance _____

Policy Number _____

Relation to Insured Self / Spouse / Parent / Child / Other

Insured's Name _____ Gender M / F

Address _____ City_____

State _____ Zip _____ DOB _____ / _____ / _____

Secondary Insurance _____

Policy Number _____

Relation to Insured Self / Spouse / Parent / Child / Other

Insured's Name _____ Gender M / F

Address _____ City_____

State ____ Zip _____ DOB _____ / _____ / _____

Emergency Contact _____ Relationship _____

Phone Numbers _____

Primary Care Doctor/Practice _____ Phone _____

How did you hear about our office? _____

Signature _____ Date _____/ _____ / _____