

Active Life Chiropractic
Nichole A Lehman, DC

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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 _____ Secondary Insurance _____

Policy Number _____ Group# _____ Policy Number _____ Group# _____

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

Insured's Name _____ Gender M / F Insured's Name _____ Gender M / F

Address _____ City _____ Address _____ City _____

State ____ Zip _____ DOB ____/____/____ State ____ Zip _____ DOB ____/____/____

Emergency Contact _____ Relationship _____

Phone Numbers _____

Primary Care Doctor/Practice _____ Phone _____

How did you hear about our office? _____

Signature _____ Date ____/____/____