Life Chiropractic & Wellness Center

APPLICATION FOR CARE

Date	ID #

PATIENT INFORMATION

Name _____MI_____ Home Phone: _____

Address _____ Cell Phone: _____

City _____ ST _____ Zip _____ Preferred Language: _____

Mailing Address: _____ Race: _____ Ethnicity: _____

Date of Birth : _____/_____/_____ *Smoking Status*: ☐ Presently ☐ Past ☐ Never

☐ Single ☐ Married ☐ Divorced ☐ Widowed *Sex* : ☐ M ☐ F *Height:* _____ *Weight*: _____

Social Security # _____/_____/_____ Driver's License # _____

E-Mail Address _____

Children: how many _____ Ages: _____

Employer _____ Occupation: _____

Work Phone: _____ - _____- _____ May we contact you at work? ☐ Y ☐ N

Primary Care Physician: _____ City: _____

Spouse's Name _____ *Date of Birth* _____ *Phone:* _____

Spouse Employed By _____ *Occupation* _____

Is your condition due to an accident? Yes ____ No ____ Date of accident? _____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Whom may we thank for referring you?

_____

How payment will be made:

_____ Health Insurance _____ Cash
_____ Workman's Comp _____ Check
_____ Auto Insurance _____ Credit Card

INSURANCE INFORMATION

Type of Insurance: _____

Subscribers Name: _____ Their Date of Birth: _____/ _____/ _____

Patient's Signature _____ **Date** _____