

ERICKSON CLINIC OF CHIROPRACTIC

ABOUT YOU

NAME _____ DATE _____

ADDRESS _____ CITY/ZIP _____

EMPLOYER _____ HOME PHONE _____

OCCUPATION _____ WORK PHONE _____ CELLULAR _____

BIRTHDATE _____ SOCIAL SECURITY # _____

NUMBER OF CHILDREN AND AGES _____ E-MAIL _____

MARITAL STATUS SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSE'S NAME _____ EMPLOYER _____

OCCUPATION _____ WORK PHONE _____

WHO REFERRED YOU TO OUR OFFICE? _____

FOR WOMEN

ANY CHANCE THAT YOU MAY BE PREGNANT? NO YES / HOW LONG?

DO YOU TAKE BIRTH CONTROL PILLS? NO YES

IN EVENT OF EMERGENCY

CONTACT _____ RELATION _____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____

ACCOUNT / INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURED'S NAME _____ SOCIAL SECURITY _____

PERSON ULTIMATELY RESPONSIBLE FOR ACCOUNT _____

RELATION _____ WORK PHONE _____

ADDRESS _____

TODAYS PAYMENT METHOD: CASH CHECK MASTERCARD / VISA
