HEALING RIVER
chiropractic

Patient Intake Form

Patient Name:_____ Date of Birth: ____/_____/_____ Sex: M/F

Address: _____
(Street) (City/State/Zip)

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

E-Mail Address: _____

Employer Name: _____ Employer Phone Number: (____) _____-_____

Primary Care Physician: _____
(Name)

How did you hear about our practice? _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____
Relationship to Patient: (please check): ( )Self, ( ) Spouse, or ( ) Parent Date of Birth: ___-___-_____

Address: _____ Phone Number: _____

Employer Name: _____ Employer Phone Number: (____) _____-_____

Employer Address: _____
(Street) (City/State/Zip)

Who to call for an emergency:
Name: _____Address: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Relationship: _____

A 24 HOUR CANCELLATION NOTICE IS REQUIRED. IF LESS THAN 24 HOUR NOTICE, A FEE FOR MISSED APPOINTMENTS WILL BE ASSESSED.

ALL SALES FINAL ON SUPPLEMENTS.

Signature: _____ Date: _____