WELCOME TO BROWER CHIROPRACTIC CENTER!

PATIENT INFORMATION

DATE:_____ / _____ / _____

FIRST NAME:_____M.I.:_____ LAST NAME:_____

CALLED NAME / NICKNAME:_____

ADDRESS:_____ SUITE OR APT #:_____

CITY:_____ STATE: NC (other)_____ ZIP _____

HOME PHONE:( ) _____ - _____ WORK PHONE:( ) _____ - _____EXT_____

GENDER: MALE FEMALE

MARITIAL STATUS: SINGLE MARRIED OTHER:_____ (please circle one)

DATE OF BIRTH: _____ / _____ / _____

SOCIAL SECURITY #: _____ - _____ - _____

DRIVERS LICENSE #:_____STATE ISSUED_____

WORK STATUS: (please circle one) EMPLOYED FULL TIME STUDENT PART TIME STUDENT

We would appreciate the following info to be used for emergency contact if we have any scheduling changes, office changes etc…) CELL # ( ) _____ - _____ Texting permitted? YES or NO
EMAIL _____@_____

REFERRED BY: Please complete this portion, it is important to us! Thank you!

( ) OUR WEBSITE: WWW.BACKHEALTHFORYOU.COM
( ) INSURANCE NETWORK/ PARTICIPATING PROVIDER LISTING
( ) PHONEBOOK (The hardcopy/paper standard White or Yellow Pages)
( ) INTERNET SEARCH, SMARTPHONE GOOGLE/YELP/FACEBOOK ETC…
( ) OTHER_____
( ) PERSON (friend, family, coworker)
NAME OF REFERRING PERSON:_____ (We like to know who to thank!)

_____ (*Initial Here*) In reading this, I acknowledge that I have been informed that a copy of the current HIPAA Notice of Privacy Practices is available for me to review or receive a copy if I request one. I understand this office follows all current HIPPA compliance requirements.

Please see separate sheet in packet to provide us with billing information if you would like us to bill another party on your behalf