PATIENT DEMOGRAPHICS

Name: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____ S.S.N.: _____

Age: _____ Sex: M F Marital Status: S M D W Number of children: _____

Employer: _____ Occupation: _____

Employer Address: _____

Employer Phone:_____

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

Spouse's Employer: _____ Spouse's Occupation: _____

Spouse's Employer Address: _____

Spouse's Employer Phone: _____

Emergency Contact:_____ Relationship: _____ Phone: _____

The following person(s) may receive private patient information via phone call or voice mail:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Our staff would like to use your name, address, email address and/or telephone number strictly for the purpose of contacting you to advise about upcoming appointments, health related meetings, referrals, workshops, and newsletters. Your personal information will neither be provided to, nor sold to any other company, organization or group. Your revocation of this authorization may be completed in writing at any time.

Name of Family Doctor: _____

Location:_____ Phone: _____

I authorize Aascend Chiropractic to inform my family doctor I'm receiving treatment here. Yes No

How did you hear about our office?

Referred by existing patient: _____ Referred by Doctor: _____

Phonebook Internet My Insurance Company Other:_____

Patient Signature: _____ Date: _____

Guardian Signature if applicable: _____Relationship: _____

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