Welcome to Mission Chiropractic & Wellness

Thank you for taking the time to complete this form.

_____ _____ _____ _____

Last Name First Name M. I. Nickname

(Name as listed on your insurance policy if applicable)

Address: _____ City, State, Zip: _____

Home Phone: _____ cell: _____ work: _____

Email: _____ Date of birth: _____ Gender: Male Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Widowed SS#_____ - _____ - _____

How were you referred? _____ Emergency contact: _____

Occupation: _____ Employer: _____

Employer address: _____ City, State, Zip _____

Have you ever had chiropractic care previously? Yes No Date of last x-rays taken: _____

If so, where and when? _____

Has anyone other than a Doctor of Chiropractic attempted to adjust your spine? Yes No

List any major falls or accidents and the approximate dates: _____

List any surgeries and approximate dates: _____

INSURANCE INFORMATION Please provide your card for our records

Insurance Coverage varies a great deal. Confirmation of coverage is not a guarantee of payment. Coverage is determined when a claim is processed by your insurance company. All uncovered services are the responsibility of the patient or their parent or guardian. I have completed the above information to the best of my knowledge and understand my responsibility.

Signature: _____ Date: _____

If the patient is a minor, a parent or guardian must indicate their consent for treatment at this facility.

Circle relationship to patient: Parent Guardian

Signature: _____ Date: _____