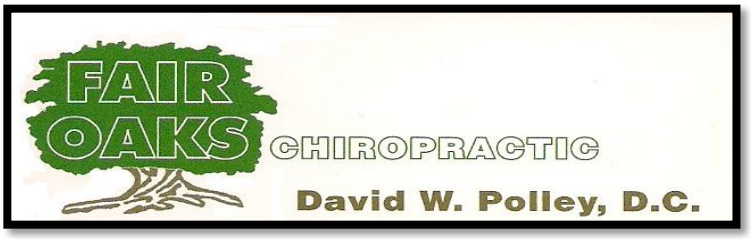

Patient Name	Date
Address	
City/State/Zip	
Phone (Home/Work/Cell)	
Email Address	
Date of Birth	Male/Female
Occupation	
Emergency Contact Name	Phone
Person who referred you?	
What is your major complaint(s)?	Date of Injury/Onset
How did it occur?	
List Dr's you have seen for this condition	
Note course of treatment and Diagnosis including X-rays	
Have you been treated for any other major health problems in the past?	

I understand all Co-payments are due on the date of my visit. If I am without insurance, I agree to pay on the day of my visit. If I do not pay my bill and my case goes to collection, I understand there will be a yearly surcharge of 20% applied to the balance.

I understand all treatments, X-rays and examinations are to be paid for as they are received or definite financial arrangements must be made in advance. I also understand and agree, if I suspend or terminate my care and treatment, any past due fees will be immediately due.

By signing below, I agree to the above and consent to the performance of chiropractic adjustment and other chiropractic procedures on me or on the patient named below, for whom I am legally responsible.

Patient Signature_____ Date_____