



New Patient Questionnaire

Patient Information				
Last name:		First name:		Middle initial:
Date of birth: / /		Age:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Social security #: - -		Driver's license #:		State issued:
Contact Information				
Address:			City:	
State:	Zip:	Email:		
Phone (check preferred contact number):			Day: () - (preferred? <input type="checkbox"/>)	
Evening: () - (preferred? <input type="checkbox"/>)		Mobile: () - (preferred? <input type="checkbox"/>)		
Employment Information				
Employer name:			Employer phone: () -	
Type of work:				
Emergency Contact				
Name:			Phone: () -	
Relationship:				
Visit Information				
Reason for visit:				
Is this visit related to (check all that apply):				
		Car accident? <input type="checkbox"/>	Injury at work? <input type="checkbox"/>	Fall? <input type="checkbox"/>
Other? (please explain):				
Is this your first visit to a chiropractor? <input type="checkbox"/> Yes <input type="checkbox"/> No			If "no", when was your last visit?	
How did you hear about Advanced Chiropractic Center?			Friend/Family? <input type="checkbox"/>	Website? <input type="checkbox"/>
Other? (please explain):				

Primary Care Physician			
Name:		Hospital/Practice affiliation:	
Address:		Phone: () -	
May we contact your primary care physician in the case of an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Would you like us to contact your physician regarding your care and treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Primary Insurance			
Insurance company:			
Group/policy #:		Member ID:	
If other than patient:	Name of insured:		
Birth date of insured: / /	Relationship to insured:		
Insured's employer:		Phone: () -	
Address of insured:	City:	State:	Zip:
Secondary Insurance			
Insurance company:			
Group/policy #:		Member ID:	
If other than patient:	Name of insured:		
Birth date of insured: / /	Relationship to insured:		
Insured's employer:		Phone: () -	
Address of insured:	City:	State:	Zip:
Would you like to be on our mailing list to receive tips for healthy living, special offers, recipes, and announcements of new services? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Patient Signature: _____ **Date:** _____

Name of parent/guardian (print): _____
 (if patient is under 18)

Signature of parent/guardian: _____ **Date:** _____

Please print completed form and bring with you to your appointment.