



Patient Number: _____

NEW PATIENT INFORMATION

Last Name: _____ Middle Name: _____ First Name: _____
Sex: M F Date of Birth: MM/____ DD/____ YY/____ Address: _____ City: _____
Province: _____ Postal Code: _____ Home Phone #: _____ Business/Cell #: _____
E-mail Address: _____ Marital Status: _____
Occupation/Employer: _____
Employer Address: _____ City: _____ Province: _____ Postal Code: _____
Spouse or Parents Name: _____
Occupation: _____ Employer's Address: _____
City: _____ Province: _____ Postal Code: _____
Family Physician: _____ Phone: _____
Emergency Contact Person (Name): _____ **Emergency Phone #:** _____
Payment Options for treatment: Visa MasterCard Cash Interact Other: _____

Insurance Information

Do you have any group, union or personal health and accident insurance? Yes No
Name of Insurance company: _____ Group #: _____
Named of Insured: _____ Relation to patient: _____ Policy: _____
Address: _____ City: _____ Province: _____
Phone #: _____ Ext: _____ Fax #: _____
Additional Insurance Company: _____ Group #: _____
Name of Insured: _____ Relation to patient: _____ Policy: _____
Address: _____ City: _____ Province: _____
Is your condition due to an accident? Yes No Is your condition due to an illness? Yes No
Did your accident occur at work? Yes No Date of accident: _____
Were you involved in an automobile accident? Yes No Date of accident: _____

If this is a work or motor vehicle injury please have all documentation available to our office

Miscellaneous Information

How did you hear about our office? _____
Individual/Advertisement? _____ Name: _____ Phone #: _____
Have you had any previous chiropractic care physiotherapy acupuncture massage therapy ?
Are you currently taking any medication or supplements? Yes No Please list: _____
Do you have any drug or other allergies? Yes No Please list: _____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____

Witness Signature: _____ Date: _____