

PATIENT INTAKE FORM
PLEASE TELL US ABOUT YOU

Today's Date ____/____/____

Full Legal Name _____

Male ___ Female ___ Single___ Married___ Widow___ Divorced___

How you prefer to be addressed _____ Birthdate ____/____/____ Age _____

Social Security # _____ - _____ - _____ E-mail address _____

Street Address _____ Home Phone ____ - ____ - ____

City _____ State _____ Zip Code _____

Employer's Name _____ What do you do there? _____

Employer's Address _____ Years with present employer _____

Work Phone # ____ - ____ - ____ Ext. # _____ Okay to call you at work? Yes No

Referred to our office by _____

In Case of Emergency Contact _____ Phone # ____ - ____ - ____ Relationship _____

INSURANCE INFORMATION

Is your current condition the result of an accident/injury? Yes ___ No ___ If yes: Auto ___ Work ___ Slip/Fall ___

Primary Insurance Company

Ins. Co. Name _____ Group # (Plan, Local or Policy #) _____

Address _____ Insured's Name _____

Relation _____ Birthdate _____

Ins. Co. Phone # _____ Insured's Social Security # _____

Insured's Employer _____ Address _____

Secondary Insurance Company

Ins. Co. Name _____ Group # (Plan, Local or Policy #) _____

Address _____ Insured's Name _____

Relation _____ Birthdate _____

Ins. Co. Phone # _____ Insured's Social Security # _____

Insured's Employer _____ Address _____

Patient Acknowledgement

By my signature, I understand and acknowledge that **CoreHealth of Clearwater LLC**, its Physicians and agents, will treat my condition as they deem necessary through the use of Chiropractic Manipulative Therapy and adjunctive therapies. I also understand that all original documents and original x-rays created as a result of the performance of examinations will remain the property of **CoreHealth of Clearwater LLC**, its Physicians and agents, will not be held responsible for any undisclosed pre-existing conditions. As the parent, guardian or parentally authorized agent, I hereby authorize **CoreHealth of Clearwater LLC**, its Physicians and agents, to administer care to this minor.

Signature of Patient (Responsible Person) _____ Date: ____/____/____