



www.peacechiro.com

Today's Date (MM/DD/YYYY)

Whom may we thank for referring you?

Gender

☐ Male ☐ Female

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (Or Initial)

Birth Date (MM/DD/YYYY)

Height

Address

Marital Status

☐ Single ☐ Married
☐ Divorced
☐ Widowed ☐ Separated

Weight

City

State

ZIP/Postal Code

Home Phone

Cell Phone

Spouse's Name

Spouse's Birth Date

E-Mail Address

Child's Name & Age

Emergency Contact

Phone

Child's Name & Age

Your Occupation

Your Employer

Child's Name & Age

Primary Physician

How can we help you today?

Acknowledgements

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials _____ I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initials _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

Initials _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

Initials _____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initials _____ I may request a copy of the Financial Policy at any time.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Signature

Date (MM/DD/YYYY)

If the patient is a minor child, print child's full name: _____

CONFIDENTIAL HEALTH INFORMATION