



PATIENT DEMOGRAPHICS

Patient Name: \_\_\_\_\_ Todays Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_(\_\_\_\_) \_\_\_\_\_ Work Phone: \_(\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

Patient Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Separated  Domestic Partner

Spouse Employed:  Yes  No Occupation: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date of Last Physical: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_

Are you currently seeing nontraditional/ alternative healthcare provider(s)?  Yes  No

If you have, which?:  Chiropractic  Acupuncture  Napropathic  Biofeedback  Reiki

Other: \_\_\_\_\_

How did you here of our center?: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

Group#: \_\_\_\_\_ Id#: \_\_\_\_\_ Insurance Phone#: \_(\_\_\_\_) \_\_\_\_\_

(Only fill out this section if patient is different from the insured)

Insured's Name: \_\_\_\_\_ Social Security#: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Insured's Home Phone: \_(\_\_\_\_) \_\_\_\_\_ Insured's Employer: \_\_\_\_\_