NEW PATIENT INFORMATION

Welcome to our office! Please complete all questions.

Full Name: _____ **Date:** _____

Address: _____ **City/State/ Zip:** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

E-Mail Address: _____ **Birthdate:** _____ **Age:** _____

Your Employer: _____ **Occupation:** _____

Marital Status: Single Married Divorced Widowed **Spouse's Name:** _____

Children's Full Names & Birthdates: _____

Emergency Contact Name & Phone: _____

How did you find out about us? (Circle all that apply)
Person _____ McClellan Website Internet Massage Patient BNI
Came here before Newspaper Phonebook Screening Sign/Location
GadsdenTimes.com Dr. Mike Dr. Leslie Dr. Taylor Other:

Insurance Co #1 _____ **Policy #** _____

Subscriber's Name: _____ **Relationship:** _____ **DOB:** _____

Address: _____ **Employer/Group Name:** _____

Insurance Co #2 _____ **Policy #** _____

Subscriber's Name: _____ **Relationship:** _____ **DOB:** _____

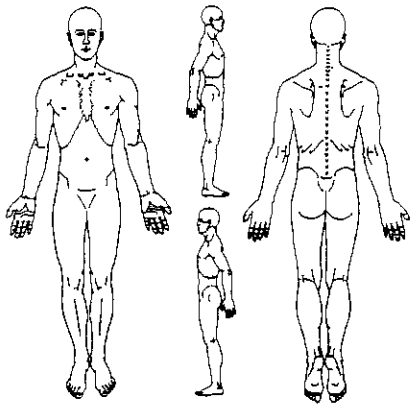
Address: _____ **Employer/Group Name:** _____

Method of Payment for First Visit: Cash Check Credit Card

Is your complaint due to an Auto Accident? Yes No **Date:** _____

Is your complaint due to a Work Injury? Yes No **Date:** _____

Please mark the location(s) of your pain



Please describe your reason for seeking treatment

_____

_____

_____

_____

Fees are payable at the time x-rays, examinations & treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient or Guardian Signature: *x* _____