PATIENT ENTRANCE FORM

Name ____ Date__________________________

Address ____

City, Province ______________________________________ Postal Code ____________________

Home Telephone __________________________ Bus. Tel. _________________________________

Date Of Birth (d/m/y) ____________________ Age ________ Marital Status- S M D W S

Spouse's Name ___________________________________ Children ______________________ ___

Occupation (Your) ____

Employer ____

Address ____

City ____ Phone ______________________________

Closest Relative __________________________________Phone _____________________________

Provincial Health Card Number ____

Extended Health Care Company ____

Policy # ______________________________ I. D. # _______________________________________

How did you hear about this office: Friend ☐ Phone book ☐ Sign ☐ Other ☐ ___________
Referred by ____

Claim will be made against:

1. Recent motor vehicle accident: Yes No (if yes, see attached)
2. Work related injury/accident Yes No (if yes, see attached)

Prior Chiropractic Care:

Name: ______________________________________Telephone ______________________________

Results: Excellent Good Fair Poor

Medical Doctor:

Name: ______________________________________ Telephone ______________________________

Address ____

Date of last appointment _____________________ Date of last physical _____________________

Did your medical doctor recommend that you seek chiropractic care? Yes No

Is it OK if we communicate with your medical doctor regarding your health condition? Yes No

Have you had any x-rays taken of your problem area? Yes No Date:_______________