

WELCOME TO BROWN CHIROPRACTIC ASSOCIATES, p.c.

Today's Date: _____

First Name: _____ M.I.: _____ Last Name: _____

Street: _____

City/Town: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ ext. _____

Fax: _____ E-mail Address: _____

Soc. Security #: _____ Age _____ Date of Birth: _____

Marital Status: S / M / D / W Spouse: _____

From whom, or what, did you learn of our office? _____

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

With regard to bill payment, will yours be sent to:

- 1) Your health insurance carrier? 2) A worker's compensation insurance?
- 3) A motor vehicle insurance? 4) Other? _____

IF MEDICARE, LAST X-RAY DATE? _____

Name of your Health Insurance plan? Primary: _____

Secondary: _____

Who is your Primary Care Physician? _____ Phone: _____

If your condition/injury has prompted you to select an attorney, please answer:

Name of Firm: _____

Name of Attorney: _____ Phone #: _____

Please complete the 'Symptom Survey' on back and, sign and date below.

Signature: _____ Date: _____