# THE CHICAGO BODY WORKS

**New Patient Information**

Name: _____ Social Security# _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Alternate Phone:_____ E-Mail:_____

Birth date: _____ Marital Status: M S W D # Children ____ Student: __Full __Part-time

Occupation: _____ Employer: _____

Describe Daily Activities:_____

Contact Name: _____ Contact Phone: _____ Referred by:_____

**Insurance Information**

Insurance Company: _____ Member ID:_____Group # _____

Name of Policy Holder: _____ D.O.B._____

Ins. Address: _____

**Health-related Information**

Are you here due to an accident? (Y or N)_____ Illness? (Y or N)_____ Other: _____

Have you had previous Chiropractic care? (Y or N)_____ If so, where and when?_____

Do you suffer from any major health conditions?_____

Medications you are currently taking:_____

**Office Policies**

Your appointment is reserved for you. We ask that you honor the late-cancellation policy to avoid a charge of $85. _____(please initial)

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. Any amount which remains past due beyond 60 days notice will be charged to my credit card.

Patient's Signature: _____ Date: _____