11216 Sunrise Blvd. E Ste 3-203
Puyallup, WA 98374
Ph: 253-864-6519 Fax: 253-864-0673

Patient's Name:____ **Gender** (Please circle one): **M F**
Address____**City**________________**State**_____**Zip**________
Home Phone #____________________**Cell Phone** #______________________**SS#**____________________
Date of Birth _____/_____/_____ **Email**:____
Race: Caucasian, African American, Asian, Native American, Hispanic, Other____________

Employer __________________________________Employer Phone#_____________________________

Marital Status: S M W D
Name of Spouse_________________________________ Spouses #_____________________________

Emergency Contact (if other than spouse):____
Relationship:_________________________________ Phone #___________________________________

<u>How did you hear about us</u>? ____

Primary Insurance: _____ Personal _____ Auto _____L&I _____Other
Name of Insurance Company____
Name of policyholder:______________________________ Date of Birth:___________________________
Self Spouse Parent Other
ID or Claim # ____________________________________ Group #______________________________

Secondary Insurance: _____ Personal _____ Auto _____L&I _____Other
Name of Insurance Company____
Name of policyholder:______________________________ Date of Birth:___________________________
Self Spouse Parent Other
ID or Claim #________________________________ Company #: _________________________________

Attorney Name__________________________ Phone #____

Have you ever been adjusted by a Chiropractor? ___________ Doctors Name___________________________
Approx. date of last visit___________ Have you seen other doctors for this condition? ___________________

Please read and sign:

I understand and agree the health and accident insurance policies and arrangements between the insurance corporation and myself. I clearly understand and agree that all services rendered to me can and be billed to my insurance company; any remaining or unpaid balance will be billed directly to me for payment. I understand any benefits given to me is a quote and not a guarantee of benefits. I also understand that if I suspend or terminate my care, any fees for services rendered to me will be immediately due and payable.
Signature_______________________________ Date______________