

Welcome Back to Marion Family Chiropractic

Today's Date _____

Date of Last Visit _____

Legal Name _____ Home/Cell phone _____

Mailing Address _____ P.O. Box _____

Town _____ State _____ Zip _____

Business Phone _____ Email _____

Marital Status _____ Name of Spouse/Partner _____

Names and Ages of Children _____

Occupation _____ Employer _____

Has your insurance company or coverage changed*? Yes No

***PLEASE provide a picture ID, your insurance card and policy holder's name & date of birth**

Reason for returning to this office (check all that apply):

- Wellness and Preventive Care To resume care plan
- Specific pain and/or health problems (please explain)

Are these reasons different than when you were in this office last? Yes No

Have you seen any other health care providers since your last visit? Yes No

If yes, whom and why?

Is there anything else that has happened in your life that we should know about since your last visit?

Please list any prescription/non-prescription medications you are taking:

(please turn over)

Demographic Data Our Federal Office of Management and Budget (OMB) has asked that we collect the following Data. No personal information is associated with this data when we send it to OMB.

- | | | | | | | | |
|--------------|---|-------------------|---------------------------------------|------------------|------------------------------------|-------------------------------------|-------------------------------------|
| Race: | <input type="checkbox"/> American Indian or Alaskan | Ethnicity: | <input type="checkbox"/> Hispanic | Language: | <input type="checkbox"/> Arabic | <input type="checkbox"/> Japanese | <input type="checkbox"/> Romanian |
| | <input type="checkbox"/> Asian | | <input type="checkbox"/> Non-Hispanic | | <input type="checkbox"/> Cantonese | <input type="checkbox"/> Korean | <input type="checkbox"/> Russian |
| | <input type="checkbox"/> Black | | <input type="checkbox"/> Declined | | <input type="checkbox"/> English | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Spanish |
| | <input type="checkbox"/> Caucasian | | | | <input type="checkbox"/> French | <input type="checkbox"/> Other | <input type="checkbox"/> Tagalog |
| | <input type="checkbox"/> Declined | | | | <input type="checkbox"/> German | <input type="checkbox"/> Persian | <input type="checkbox"/> Ukrainian |
| | <input type="checkbox"/> Other Race | | | | <input type="checkbox"/> Hindi | <input type="checkbox"/> Polish | <input type="checkbox"/> Urdu |
| | <input type="checkbox"/> Pacific Islander | | | | <input type="checkbox"/> Italian | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Vietnamese |

Name of person responsible for account _____

Insurance Subscriber Name: _____

DOB: ____/____/____

Subscriber Complete

Address: _____

Signature X _____ Date _____

Welcome Back. We look forward to providing your chiropractic care.

Dr. Jennifer F. Eames
Dr. Allison Baker