FOOTHILLS FAMILY CHIROPRACTIC

PATIENT INFORMATION FORM

Name: Last _____ First:_____ MI:_____

Address: City:_____ Province: _____

Postal Code: _____ E-mail address: _____

Cell Phone: _____ Home Phone: _____ Work: _____

Age: _____ Birth Date: _____ Alberta Health#: _____

Occupation: _____ Employer: _____

Marital Status: _____ Name of Spouse: _____

Family Medical Doctor: _____ Location: _____

Emergency Contact: _____ Phone: _____

List your medications and the condition you take them for:

How did you hear about our office?

Date of last spinal or hip x-ray: Where was it taken?

INJURY CLAIM ONLY: WCB? ☐ YES ☐ NO **MOTOR VEHICLE ACCIDENT?** ☐ YES ☐ NO

WOMEN ONLY: Are you Pregnant ☐ YES ☐ NO ☐ UNSURE # of Weeks:

OB/Midwife/Doula: Other Practitioner:

Do you have extended health benefits? ☐ YES ☐ NO

Primary Insurance Company: Primary Group #:

Secondary Insurance Company: Secondary Group #:

When doctors/therapists work together it benefits you. May we have your permission to update your health care practitioner(s) regarding your care at this office? ☐ YES ☐ NO

LATE CANCELLATIONS AND NO SHOW POLICY

We require a MINIMUM of 24-hours notice to cancel or change appointments.

ALL late cancellations and no-show appointments are subject to a 50% fee of the affected bookings

Initial: _____