



**MEANS FAMILY
CHIROPRACTIC**

PATIENT INTRODUCTION CARD

File No. _____

NAME _____ DATE _____ MARITAL STATUS:
 ADDRESS _____ PHONE _____ Single _____
 CITY _____ STATE _____ ZIP _____ Married _____
 DATE OF BIRTH _____ AGE _____ HT. _____ WT. _____ Divorced _____
 CELL PHONE _____ EMAIL ADDRESS _____ Separated _____
 Widowed _____

No. in immediate family presently being treated in this office _____ NO. OF CHILDREN _____

Occupation _____ Social Security Number _____

Employed by _____ Business Phone _____

Name of Spouse _____ Employed by _____

Business Phone _____

In Case of Emergency: _____ Have you received chiropractic care before? _____

If so, where? _____

DO YOU HAVE HEALTH INSURANCE? _____ WHAT COMPANY? _____

Charges for todays services will be paid by _____ Cash _____ Check _____ Visa _____ Mastercard _____ Other

"Our purpose is to educate and adjust as many families as possible through Specific Chiropractic Care"