

# PATIENT ENTRANCE FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City, Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Telephone \_\_\_\_\_ Bus. Tel. \_\_\_\_\_

Date Of Birth (d/m/y) \_\_\_\_\_ Age \_\_\_\_\_ Marital Status- S M D W S

Spouse's Name \_\_\_\_\_ Children \_\_\_\_\_

Occupation (Your) \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Phone \_\_\_\_\_

Closest Relative \_\_\_\_\_ Phone \_\_\_\_\_

Provincial Health Card Number \_\_\_\_\_

Extended Health Care Company \_\_\_\_\_

Policy # \_\_\_\_\_ I. D. # \_\_\_\_\_

How did you hear about this office: Friend  Phone book  Sign  Other  \_\_\_\_\_  
Referred by \_\_\_\_\_

## Claim will be made against:

- |                                   |     |                           |
|-----------------------------------|-----|---------------------------|
| 1. Recent motor vehicle accident: | Yes | No (if yes, see attached) |
| 2. Work related injury/accident   | Yes | No (if yes, see attached) |

## Prior Chiropractic Care:

Name: \_\_\_\_\_ Telephone \_\_\_\_\_

Results:      Excellent      Good      Fair      Poor

## Medical Doctor:

Name: \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Date of last appointment \_\_\_\_\_ Date of last physical \_\_\_\_\_

Did your medical doctor recommend that you seek chiropractic care?      Yes      No

Is it OK if we communicate with your medical doctor regarding your health condition?      Yes      No

Have any x-rays been taken on your spine?      Yes      No      Date: \_\_\_\_\_