



PATIENT INFORMATION

Date _____ Case # _____

Name _____ D.O.B. _____ Age _____ Sex _____
Last First M.I.

Address _____
Street City State Zip

Home Phone _____ Marital Status: M S D W (circle) SS# _____

Cell Number: _____ Email address _____

Business Phone _____ Occupation _____ Full / Part / Retired

Employer _____ Address _____

Primary Insurance _____ Member# _____ Group # _____

Insured's Name _____ Date of Birth _____ Employer _____

Secondary Insurance _____ Member# _____ Group # _____

Insured's Name _____ Date of Birth _____ Employer _____

Spouse's Name: _____ Children's Name(s) _____

Are you seeking: _____ Temporary Relief _____ Optimum Correction / Greater Total Health

Whom can we thank for referring you to our office? _____

If this is work or auto related, please ask for an additional form at the front desk.

Please read and sign below:

I understand that payment is due and expected today at the time the services are rendered. I understand any necessary x-rays remain the property of this office. I understand that an interest charge will be applied to any outstanding balances that I am responsible for after 30 days. I have read and agree to the above statements.

Patient Signature: _____ Date: _____

Parent Signature (if patient is a minor): _____ Date: _____

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www.UpstateChiropractic.com

"An Optimal Spine = Optimal Health"