SOUND CHIROPRACTIC & WELLNESS CLINIC

PATIENT REGISTRATION

Name:	**Date:**	
Home Address:	**City:**	**Postal Code:**
Phone #	**Alt phone #**	
Sex: **F ☐ M ☐**	**Email:**	
Date of Birth **MM DD YY**	**Age:**	**Marital Status:**
Occupation:		
How did you hear about our clinic?		
Have you received previous Chiropractic care? **Yes ☐ No ☐**	**If yes:** **When was your last appointment?_____** **Who was your previous chiropractor?_____**	

EMERGENCY CONTACT

Emergency Contact Name:	**Relation:**	**Phone #:**

INSURANCE INFORMATION

Extended Health Insurance **Yes ☐ No ☐**	**If yes what company?**
Group #	**ID#**