Welcome Back to Marion Family Chiropractic

Today's Date _____ Date of Last Visit_____

Legal Name _____ Home/Cell phone _____

Mailing Address _____ P.O. Box _____

Town _____ State _____Zip _____

Business Phone _____ Email _____

Marital Status _____ Name of Spouse/Partner _____

Names and Ages of Children _____

Occupation _____ Employer _____

Has your insurance company or coverage changed*? □ **Yes** □ **No**

***PLEASE provide a picture ID, your insurance card and policy holder's name & date of birth**

Reason for returning to this office (check all that apply):

□ Wellness and Preventive Care □ To resume care plan

□ Specific pain and/or health problems (please explain)

_____

_____

Are these reasons different than when you were in this office last? □ **Yes** □ **No**

Have you seen any other health care providers since your last visit? □ **Yes** □ **No**

If yes, whom and why?

_____

_____

Is there anything else that has happened in your life that we should know about since your last visit?

_____

Please list any prescription/non-prescription medications you are taking :

(please turn over)

_____

Demographic Data Our Federal Office of Management and Budget (OMB) has asked that we collect the following Data. No personal information is associated with this data when we send it to OMB.

Race:
- □ American Indian or Alaskan
- □ Asian
- □ Black
- □ Caucasian
- □ Declined
- □ Other Race
- □ Pacific Islander

Ethnicity:
- □ Hispanic
- □ Non-Hispanic
- □ Declined

Language:
- □ Arabic
- □ Cantonese
- □ English
- □ French
- □ German
- □ Hindi
- □ Italian
- □ Portuguese
- □ Japanese
- □ Korean
- □ Mandarin
- □ Other
- □ Persian
- □ Polish
- □ Vietnamese
- □ Romanian
- □ Russian
- □ Spanish
- □ Tagalog
- □ Ukrainian
- □ Urdu

Name of person responsible for account _____

Insurance Subscriber Name:_____
DOB:_____/_____/_____

Subscriber Complete
Address:_____

Signature X_____ Date _____

Welcome Back. We look forward to providing your chiropractic care.

Dr. Jennifer F. Eames
Dr. Belinda L. Marcil