To assist you in providing the best possible care, please fill out this form as accurately as you can. All the information provided will be kept confidential in your patient file.

Today's Date:_____

First Name:_____Middle Initial_____Last:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Email:_____

Date of Birth:_____ Gender: Female Male

Preferred method of contact (circle one): *home cell* May we leave a message: *yes no*

Employment Status (circle one): *Employed Unemployed Student Student Retired*

Marital Status (circle one): *Single Married Other*

Primary Care Physician:_____ Phone:_____

Referred By: _____

Payment/Insurance Information

Who is responsible for your bill? (circle one): *Self (no insurance) Health Insurance Other*

Other Worker's Comp Auto Insurance

Personal Health Insurance Carrier:_____

Insurance ID#:_____ Group #:_____

Policy Holder's Name:_____Relationship:_____

Policy Holder's Date of Birth : _____/_____/_____

Policy Holder's Address: _____

Secondary Insurance: _____

Emergency Contact and Phone #: _____

I authorize Hoffmann Chiropractic to deliver text messaging using an automatic dialing system. I consent to such messages be delivered to:

Cellphone:_____

Signature:_____