Spinal Wellness Chiropractic

2010 N. Plano Rd suite 101, Richardson, TX 75082

Patient Registration Document

Patient Information (please print clearly)

Name: (Last) _____(First)_____(M)_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone_____ Email Address: _____

SSN #: _____ DOB: _____ Age: _____ Sex: **M** **F**

Marital Status: **S**ingle **M**arried **W**idowed **D**ivorced Number of Children: _____

Previous Chiropractic Treatment: **Y** **N** Referred by: Radio Mag __ Friend_____Other:_____

Work Information (please print clearly)

Employer's Name: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Occupation: _____

Spouse Information (please print clearly)

Name: _____

DOB: _____SSN#:_____Occupation: _____Employer: _____

In case of Emergency (please print clearly)

Contact Person: _____

Contact Phone Number: _____ Relation: _____

Primary Care Physician Name: _____ Phone: _____

I understand and agree to authorize the doctors or staffs to administer examination procedures and treatments, as deemed necessary:

Patient's Signature: _____ **Date**: _____

Consent to treat a minor: _____ Date: _____

Guardian or Spouse's Signature of Authorizing Care: _____ Date: _____