ORLANDO FAMILY CHIROPRACTIC CENTER | 210 SCOTCH ROAD | EWING, NJ | 08628

New Patient Form

Today's Date: ________________________ Date of Birth ________________________

Print Name: ____

Street Address: ____

City: ____ State: _________ Zip Code: __________________

Home Phone: _________________________________ Mobile Phone: ______________________________

Referred By (How did you hear about us?): ____

Have you ever been to a Chiropractor: Yes No If so, when was your last visit? ________________

Reason for Visit: ____

If visit is due to a specific complaint, when did it start? _______________________________________

Other health problems that you may be experiencing: ____

Current Medications: ____

Have you ever had spinal surgery? Yes No If so, when? _____________________________________

Other surgeries? Yes No Details: ____

____

Is this visit due to an automobile accident? Yes No

Is this visit due to another type of accident? Yes No If so, please explain: ________________________

____

Are you using a lawyer's services? Yes No Lawyer's Name: ________________________________

Facility Name: ____ Phone Number: ___________________

Do you have health insurance? Yes No If so, please provide your cards to the front desk and fill in the following:

Policy Holder's Name: ____

Policy Holder's Date of Birth: ______________________________

Policy Holder's Relationship to Patient: ____

Policy Holder's Address (if different from address listed above):

Street Address: ____

City: ____________________________________ State: _________ Zip Code: _____________

I understand that I am responsible for charges not covered by my insurance company (deductible, co-payments, etc.). If I do not have insurance coverage I am fully responsible for all incurred charges.

Signature: ____ Date:________________________