Montpelier Chiropractic Center Confidential Patient Information

Name: _____

SSN: _____Date of Birth: ___/___/____*

Address:_____

City/State:_____ Zip Code:_____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____

Email: _____

Employer: _____

Occupation: _____

Sex: Male/Female Marital Status: S M D W

Name of Spouse (if applicable):_____

Emergency Contact:

Name/Relationship to patient: _____

Phone Number: (____) _____

Referred By: _____

We frequently send a note of appreciation to our patients who refer other patients. May we identify you when sending a "thank you" to the above mentioned individual?

_____ *Yes Please initial:* _____

Family Physician: _____

May the doctor contact your physician concerning your condition and care?

_____ *Yes Please initial:* _____

***If patient is a minor (under the age of 18), a legal guardian must read and sign the following statement:**

I, _____, give Joshua M. Schlade permission to assess the condition of _____, and perform therapy, render care, or refer as he sees fit in the best interest of the patient.

Guardian Signature: _____ Date: ____/____/____.