COMMUNITY CHIROPRACTIC & ACUPUNCTURE

Date: _____ Referred by: _____

Name (Last, First): _____ Social Security #_____

Address: _____ Phone #_____

City/State/Zip: _____E-Mail: _____

DOB: _____ Age: _____ M_____ F_____

Marital Status: _____ Children: _____Ages: _____

Occupation: _____ Work Phone # _____

Name of Employer: _____

Employer Address: _____

Spouse/Partner (or parent, if minor) _____

Occupation: _____ Work Phone # _____

Name of Employer: _____

Employer Address: _____

Previous Chiropractic Care: _____

Previous Acupuncture Care: _____

I agree to be responsible for all fees due upon failure of my insurance company to reimburse Dr. Karen A. Thomas in a timely manner:

_____
Signature of Patient
(Or parent, if minor)