TOTAL HEALTH CHIROPRACTIC

2624 S. Milford Rd., Highland, MI 48357 Phone: 248-684-4449 Fax: 248-684-4413 Dr. Michael Sadowski, Chiropractor

WELCOME TO OUR OFFICE

DATE: _____

NAME: _____ MALE_____ FEMALE_____

WHAT NAME DO YOU PREFER TO BE CALLED? _____

SOCIAL SECURITY NUMBER: _____-_____-_____ DATE OF BIRTH ____/____/_____

SINGLE _____ MARRIED _____ DIVORCED _____ WIDOWED _____ # OF CHILDREN _____

(If Female) I STATE, TO THE BEST OF MY KNOWLEDGE, (circle one) I AM/AM NOT PREGNANT.

ADDRESS:_____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: ( ) _____ - _____ CELL/WORK: ( ) _____ - _____
(CIRCLE ONE)

E-MAIL ADDRESS: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMPLOYER INFORMATION

NAME OF EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____ INSURED'S NAME: _____

RELATION: _____ DATE OF BIRTH: _____/_____/_____

EMPLOYER: _____ ADDRESS: _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I authorize payment of benefits directly to the provider for the services rendered. I further authorize the release of any information to process insurance claims. Our office requires payment in full for all services rendered.

Signature: _____ Date: _____