

# Gregg Chiropractic Center, Inc.

## Patient History

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

H. Phone (\_\_\_\_\_) \_\_\_\_\_ C. Phone \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Referred by \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Email Address \_\_\_\_\_ Marital Status S M D W Spouse Name \_\_\_\_\_

Number of Children/Ages \_\_\_\_\_ Spouses Occupation \_\_\_\_\_

Have you ever received Chiropractic Care? Yes No Do you have Health Insurance? Yes No Name of Company \_\_\_\_\_

How will you be paying for today? Cash Check Visa Mastercard Discover AMEX