



MORRISON
CHIROPRACTIC, P.A.
Gentle, Effective, Quality Chiropractic Care

NEW PATIENT INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____

Phone: Home: _____ Work: _____ Cell: _____

E-mail address: _____

Sex: M F Social Security #: _____ Marital Status(Circle One) M S W D Child/Student

Consent to examine/treat child under 18 years of age: _____

Parent/Guardian Signature

Employer: _____ Occupation: _____

Spouse/Parent Information: _____

Name	Date of Birth	Phone	Employer
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Emergency Contact: _____
(not living with you) Name Relationship Phone

Address	City	State	Zip
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Method of Payment: Cash _____ Check _____ Credit Card _____ Insurance _____

Not all insurance plans are accepted by our office, nor do all insurances include chiropractic benefits. As a participating provider with certain insurances, your co-pay will be due today. We will verify all coverage and benefits and share this information with you at your report of findings visit.

Attention Medicare Patients: Please show your card to our patient service representative.