NESTLE CHIROPRACTIC CENTER
CASE HISTORY RECORD

Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Mailing Address _____ City _____ Zip _____

Home Phone _____ Birthday Mo___ Day___ Yr___ Age _____ Sex _____

Are you employed outside the home? ☐ Yes ☐ No ☐ Fulltime ☐ Parttime Cell Phone _____

Name of Your Employer _____ Occupation _____

Address _____ Work Phone _____ Ext. _____

Your Insurance Company _____

Address _____ Effective Date _____

Group No. _____ Policy No. _____ Your S.S. No. _____

Marital Status ☐ M ☐ S ☐ D ☐ W Number of Children _____

Spouse's Name _____ His/Her SS No. _____

Spouse's Employer _____ Work Phone _____ Ext. _____

Address _____

Spouse's Insurance Company _____

Address _____

Group No. _____ Policy No. _____ Effective Date _____

Nearest relative not living with you _____ Relation _____ Phone _____

Nearest friend not living with you _____ Phone No. _____

Physician _____ Phone _____ Dentist _____ Phone _____

Whom may we contact in case of an emergency? _____ Phone _____

Whom may we thank for referring you to us? _____ Phone _____

Who is financially responsible for this bill? _____

I will be paying today by CASH _____ CHECK _____ CREDIT CARD _____

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ Date _____
Signature

_____ Date _____
Parent (if minor)