BENNION CHIROPRACTIC

Whole Body Wellness for the Whole Family

Patient Information Form

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ Marital Status: S M W D SEP

Social Security #: _____-_____-_____

Street Address: _____ Apt#:_____

City:_____ State:_____ Zip:_____

Home phone #: (_____)_____-_____

Work phone #: (_____)_____-_____

Cell phone #: (_____)_____-_____

Email Address:_____

****

Insurance Co. Name: _____

Insurance Co. Phone #: (_____)_____-_____

Member ID #: _____ Group #:_____

****

Emergency Contact: _____

Relationship: _____ Phone #: (_____)_____-_____

Primary Care Dr: _____ Phone: (_____)_____-_____

Records Release Authorization

I hereby grant permission for Bennion Chiropractic to release any information pertaining to diagnosis and treatment of myself and care in this and other offices to my primary care physician, or to any other physician or therapist with who I am currently or previously under care.

Signature_____ Date_____