2025 Flour Bluff Dr.
Corpus Christi TX 78418
(361) 937-1215

PATIENT INFORMATION

Date: _____

How did you hear about our office?: _____

Name: _____
First M. Last

Address: _____
Street city state zip

Home phone # _____ work # _____ cell # _____

Birth date: __/___/____ age: _____ Sex**: M F** Marital status: **S M D W**

Occupation: _____SS#: _____

Emergency contact: _____ phone: _____

Have you had chiropractic care before? **Y N**

Primary care physician: _____ phone # _____

Describe today's symptoms: _____

Dominant Hand**: R L Both**

FINANCIAL POLICY:

Payment is due at the time services are rendered. If we are filing insurance for you, please be aware that this is an agreement between you and your insurance company to pay for certain amounts of medical care. You are responsible for any payment not covered by insurance, or not paid in a timely manner by your insurance company.

If you must cancel an appointment, kindly give 24 hours notice. **If you fail to show up for a massage without canceling 24 hours in advance, you will be charged for the appointment.**

I have read, understand and agree to the provisions of this financial policy. A photocopy of this instrument shall serve as the original.

Signature: _____ Date: _____