# Harchak Chiropractic Clinic LLC

## PATIENT INFORMATION

### PATIENT NAME:

Last Name ________________________ First ______________________ Middle _______________

Gender: Male◯ Female◯ Date of Birth ____ / ____ / ____ Age ______

SS# _____________________________________________

Home Address_______________________________________________________________________

City ________________________________________________ State_ _____________________

Zip_______________________

Home Phone ___________________________ Cell Phone _ ______________________________

Personal Email:______________________________________________________________________

Employer Name _____________________________________ Phone_________________________

Employer Address ___________________________________________________________________

City ________________________________________________ State_ ____ Zip_______________

### SPOUSE *or* GUARDIAN:

Last Name ___________________________ First ______________________ Middle __________________

Employer Name _____________________________________ Phone _____________________

_________________________________

Date of Birth ____/____/____ SS# __________________________

**EMERGENCY:** *Name and address of nearest relative or friend not living with you.*

Last Name _________________________ First __________________________ Middle ________________

Home Phone ___________________ Cell Phone _____________________ Work

Phone__________________

Relation to Patient

__________________________________________________________________________

**PAYMENT METHOD:** For all services that are not paid by a third party (Insurance, Medicare, Medicaid).

Cash ◯ Check ◯ Visa ◯ Mastercard ◯ Discover ◯ American Express ◯

*If you have any insurance coverage that might pay a portion of your financial obligations, please ask about our policy.*

## MY CERTIFICATION

I certify that the above information is correct and I request services.

x _____________________________________________________________________________

*Signature of patient or person acting on patient's behalf* *Date*

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