# Johnson Chiropractic Inc.

*Making Health a Way of Life!*

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**IS YOUR VISIT DUE TO AN ACCIDENT OR INJURY? [ ] YES [ ] NO**

**HOW DID YOU HEAR ABOUT US?** ______________________________________________

NAME: ______________________________________________
Last First Middle Initial

DATE OF BIRTH: _____/_____/_____ AGE: _____

ADDRESS: ________________________ CITY: ____________ STATE: ____ ZIP: ______

HOME PHONE: (     ) _____-______

CELL PHONE: (     ) _____-______

STATUS: [ ] Married [ ] Single [ ] Divorced [ ] Widowed NUMBER OF CHILDREN: _____

EMPLOYER: ________________________ ADDRESS: ____________________________

WORK PHONE: (     ) _____-__________

***IF MARRIED, PLEASE FILL IN THE FOLLOWING:***

NAME OF SPOUSE: ____________________________ SPOUSE DOB: _____/_____/_____

SPOUSE'S EMPLOYER: ________________________ WORK PHONE: (     ) _____-______

*NAME OF NEAREST RELATIVE NOT LIVING WITH YOU:* ____________________________

ADDRESS: ____________________________________ HOME PHONE: (     ) _____-______

RELATIONSHIP: ______________________________

***WHO IS RESPONSIBLE PARTY AND/OR GUARDIAN FOR THIS ACCOUNT?***

____________________________________________________________

PHONE: (     ) _____-______ ADDRESS: ____________________________________

**CO-PAY AND/OR COINSURANCE IS EXPECTED AT THE TIME OF SERVICE. YOU MAY CHOOSE TO PAY THE END OF THE WEEK IF MORE THAN ONE WEEKLY VISIT. WE ACCEPT PAYMENT IN THE FORM OF CASH, CHECK OR CREDIT CARD.**

**LATE CHARGES:** **IN THE EVENT OF DEFAULT ON PAYMENT OF THE ACCOUNT, I AGREE TO PAY COLLECTIONS COSTS AND REASONABLE ATTORNEY FEES INCURRED IN ATTEMPTING TO COLLECT ON THIS AMOUNT OR ANY FUTURE OUTSTANDING ACCOUNT BALANCES.**

**PATIENT OR PARENT/GUARDIAN SIGNATURE:** ______________________________
**DATE:** _____/_____/_____