



1314 Center Dr, Unit F, Medford, OR 97501
Phone (541) 857-2678
Fax (541) 857-2028

Patient Demographic Information

The form below can be used in-lieu of filling out forms at the office. Another option is to fax the completed form to the office.

Date _____

Patient _____ Birthdate _____ Age _____
(Full Name, Please Do Not Use Initials)

Single ___ Divorce ___ Married ___ Widowed ___ Male ___ Female ___

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Patient Employed by _____ Occupation _____

Business Address _____

City _____ State _____ Zip Code _____ Business Phone _____

Name of Spouse _____ DOB _____

Spouse Employed by _____ Business Phone _____

Number of Children and Ages: _____

Other Nearest Relative or Contact Person: _____ Phone: _____

Have you received chiropractic care in the past? Yes ___ No ___ When? _____

Have you received physical therapy in the past? Yes ___ No ___ When? _____

If yes, please give the name of the Chiropractor or Physical Therapist: _____

Please describe the reason for previous care: _____

Please describe the reason for PRESENT care: _____

Name of your Medical Doctor: _____

PATIENT REFERRED by _____



IF PATIENT IS A MINOR, COMPLETE THIS SECTION

Father: Name _____ **DOB** _____

Employer _____ Employer Phone _____

Mother: Name _____ **DOB** _____

Employer _____ Employer Phone _____

HOME ADDRESS OF PARENT(S) if different than patient's _____

_____ Phone _____

INSURANCE INFORMATION

Company Name _____ Certificate # _____

Address _____

Secondary Insurance _____ Certificate # _____

Address _____

Job Related Injury (Worker's Compensation): Yes ____ No ____

Worker's Compensation Claim Number _____

Contact Person or Adjuster _____

Contact Person or Adjuster Phone Number _____

Address _____

If you have consulted an Attorney, please provide the following information:

Attorney's Name: _____

Phone: _____

Attorney's Address: _____