Welcome to Natural Family Healthcare

Legal Name : ______________________________ Date : ___________ 20 __

Address ____

Street City State Zip

Best Phone # ______________________ Is it a cell? ☐ May we text it? ☐

Email : _________________________ Date of Birth ____________

Circle one: Single Married Widowed Separated Divorced Full / Part Time Student

Do you want us to bill Insurance? ___ Yes ____ No

If yes, Who Holds insurance policy? Me, Spouse, Parent, Workers Comp, Auto Accident

Insured's Name ______________________ DOB ___________ Is their address different? Yes / No

Insurance Company name :

Have you seen a Chiropractor before? Yes / No

How did you hear of us? ____

I hereby authorize and consent to treatment by Dr. Jill House. No guarantee has been made as to the results that may be obtained. I hereby authorize Natural Family Healthcare to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I authorize my insurance company to pay Dr. Jill House directly.

Patient's or Guardian Signature ______________________________

If you have Insurance, please give your card and Driver's License to the receptionist for her to photocopy. You are responsible for knowing your own benefits under your plan. Info told to us by your Insurance is not guaranteed.

In case of emergency, contact? ____________________ ________________________

name phone number

Who is your Primary MD? ______________________________ city ________________

May we update them on your status and request records from them if needed? Yes / no

Main reason for your visit today ? ______________________________________'

When did the above start ? _________________ (If chronic, date of recent flare up)

Please bring in a list (or write on back) of medications / vitamins you currently take regularly.