DATE	I.D. NO.

MIAMI HEIGHTS CHIROPRACTIC CENTER
A GONSTEAD METHOD

Personal History

Name _____ Address _____

City _____ State _____ Zip Code _____

Birth Date _____ Age _____ Sex: ☐ Male ☐ Female

Home Phone _____ Cell Phone _____

Email Address _____

Social Security # _____ Driver's License Number _____

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Business Employer _____ Type of Work _____

Business Phone _____

Name of Spouse _____

Spouse's Social Security # _____ Spouse's Employer _____

Business Phone _____ Type of Work _____

Name and Ages of Children _____

Referred to this Office by _____

Emergency Contact

Name _____ Phone Number _____ Relationship _____

Who is Responsible for Your Bill (You and one of the following are responsible for your bill). Please choose one.

☐ Spouse ☐ Workers' Comp. ☐ Auto Insurance ☐ Medicare ☐ Medicaid

☐ Personal Health Insurance (Name) _____

☐ Health Card # _____

Insured Person's Name _____ Date of Birth _____