FORD CHIROPRACTIC
1304 N. MAIN STREET -- LAFAYETTE, GA 30728

Full Name: ____
(First) (MI) (Last)

Address: ____
(Street) (City) (State) (Zip)

Phone: _________________________ Cell Phone: _______________________

Birth Date: ___/___/____ Social Security #: ___-__-____ Gender:M ( ) F ( )

Marital Status: M S D W Sep. Minor

Spouse's Name: ____

Spouse's Social Security #: ________________ Spouse Birth Date: _______

E-Mail Address: ____

Referred By: Newspaper Ad ( ) TV Ad ( ) Radio Ad ( ) Personal ( )

Name of Personal Referral: ____

Other: ____

Employer: ____
(Name) (Address – City/State/Zip)

Employer Phone: ______________________________ ext: _______________

Primary Care Physician: ____
(Physician Name / Group Name)

Address: ____________________________________ Phone: _______________

Is your visit due to an Injury? Yes ( ) No ( ) If yes, please mark one of the following:

Auto Accident ( ) Personal Injury ( ) Work Injury ( ) Other ( )

Primary Insurance Company Name: ________________________________

Secondary Insurance Company Name: _______________________________

Attorney: ____
(Name) (Address) (Phone)

I CERTIFY THAT THE INFORMATION THAT I HAVE PROVIDED ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER GIVE THIS OFFICE PERMISSION TO SEND REPORTS OF DR. FORD'S FINDINGS TO MY PRIMARY CARE PHYSICIAN LISTED ABOVE.

X____
(Patient Signature) (Date)