REAVES CHIROPRACTIC HEALTH CENTRE, INC

Patient Information Form

Date: _____ (Office info) File #: _____

Patient Name: _____ _____ _____ DOB: _____
(First) (Maiden/Middle) (Last)

Title: ☐ Dr. ☐ Rev. ☐ Other: _____ ☐ Jr. ☐ Sr. ☐ II ☐ III Age: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated Sex: ☐ M ☐ F

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home _____ Cell # _____ Work # _____
Email Address: _____

Employer Name: _____ Phone #: _____
Occupation/Job Title: _____ Social Security #: _____

Emergency Contact Name: _____ Phone #: _____
Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Insurance Information: (please have current insurance card available)

Name of Insurance: _____ PCP: _____
Policy ID #: _____ Group #: _____
Policy Holder's Name: _____ Policy Holder's DOB: _____
Address (if different): _____ Contact #: _____
_____
Employer: _____

*** Race:**
☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Decline to Provide

* **Ethnicity:** (check one) ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Decline to Provide

* **Preferred Language:** ☐ English ☐ Other _____ Additional Languages:_____

Social History:

☐ Current Smoker Amt/Frequency? _____ Additional Tobacco/Nicotine Used: Current/Past
☐ Quit Smoking When? ☐ Chew ☐ Dip ☐ E Cig/Vapor ☐ Cigar
☐ Never Smoked ☐ 2nd Hand Smoke Exposure ☐ Other _____ Amount _____

Alcohol Consumption: ☐ Never ☐ Social Consumption Only ☐ Daily ☐ Weekly ☐ Monthly ☐ Seldom

Education Level: (mark highest level completed or currently attending) ☐ Elementary ☐ Middle ☐ Junior High
☐ In High School ☐ High School Diploma ☐ Did Not Finish High School ☐ Post High School Classes ☐ Votech
☐ Associate/Technical Degree ☐ In College ☐ College Degree ☐ In Graduate School ☐ Graduate Degree
☐ Doctorate ☐ Other _____