LOGAN UNIVERSITY
CHIROPRACTIC HEALTH CENTERS

New Patient Profile

First Name: _____ Initial: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact: _____ Phone Number: _____

Gender: □ Male □ Female Marital Status: □ M □ S □ D □ W

Work Status: □ Employed □ Retired □ P/T Student □ F/T Student □ Unemployed

Employer: _____

Name of Insurance: _____ Insured Name: _____

Insured's ID#: _____ Insured's Date of Birth: _____

Person responsible for paying the bills if other than above:

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____

Do you have Medicare or a Medicare Replacement Insurance Plan? □ Yes □ No

Do you have Medicaid? □ Yes □ No

Accident/Injury Information

Is today's visit related to employment? □ Yes □ No

Is today's visit related to an automobile accident? □ Yes □ No

Is today's visit related to another type of accident? □ Yes □ No

If you answered Yes to any of the questions, please list the state in which the accident occurred: _____

What was the date of the accident? _____

Has this been a problem in the past? If so, please list and give the date: _____

If there is a referring physician, please list his/her name: _____

Print name and sign: _____ Date: _____

Office use only:

Category: _____ Type of Account: _____ Account Number: _____ Doctor ID: _____ Intern Name: _____

Montgomery Health Center	Mid Rivers/94 Health Center	Southfield Health Center
636-230-1990	636-397-3545	314-849-3800

Updated: 7/5/16