

# Westport Chiropractic

## ENTRANCE APPLICATION

**WELCOME! ...WE ARE HONORED YOU CHOSE US TO EVALUATE YOUR CONDITION. SO WE MAY FILE YOUR INSURANCE FORMS FOR YOU, WOULD YOU PLEASE FILL OUT THE PERSON. THANK YOU! INFORMATION BELOW? IF YOU NEED ASSISTANCE PLEASE INFORM THE FRONT DESK**

First name _____	Middle _____	Last _____
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone _____	
Address _____		
City _____	State _____	Zip _____
Social Security Number ____ - ____ - ____	E-mail Address _____	
Birthday _____	Age _____	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D
Employer _____		
Job Title _____	Work Phone _____	
<b>Responsible Party</b> _____	D.O.B _____	
Social Security Number ____ - ____ - ____		
Name of person on your health insurance card _____		
Name of their employer _____	City _____	
Employer Phone _____		
Children--Names & Ages _____		
_____		
In case of emergency, whom should we contact? _____		
Phone _____		
FAMILY PHYSICIAN _____		
What is your primary complaint? _____		
_____		
_____		
_____		
IS THIS WORKMAN'S COMPENSATION? _____ IS THIS AN AUTO ACCIDENT? _____		

<b>(Office use only)</b>	<b>Account Number</b>	<b>Date</b>
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