BACK IN MOTION CHIROPRACTIC
4341 B Street Ste 100 ▪ Anchorage, Alaska 99503 ▪ (907) 562-CARE

WELCOME!!

PATIENT INFORMATION

Thank you for choosing our practice for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ **Date** _____
First MI Last

Address _____ **City** _____ **State** _____ **Zip** _____

Sex: ☐ Female ☐ Male **Birth date:**_____/_____/_____ **SSN** _____-_____-_____

Home phone ( ) _____ **Work phone** ( )_____ **Cell phone** ( ) _____

E-mail:_____ **Text message:**_____

Are you: ☐ Minor ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Partnered

Approximate weight _____ **pounds** **Approximate height** _____ **feet** _____ **inches**

Your employer _____ **Occupation** _____

Business Address _____ **City** _____ **State** _____ **Zip**_____

Emergency Contact _____ **Emergency phone** ( )_____

Spouse's Name _____ **Occupation**_____ **Employer** _____

Whom may we thank for referring you to us? _____

RESPONSIBLE PARTY/INSURANCE INFORMATION

☐ **SELF** ☐ **PARENT/GUARDIAN**

INSURANCE INFORMATION (Primary coverage) Please provide your insurance card(s)

Name of Insured _____ ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT**

Birth date of policy holder: _____/_____/_____ **SSN** _____-_____-_____

Name of employer: ☐ Same as above_____ **Work phone** ( ) _____

Address _____ **City** _____ **State** _____ **Zip** _____

Insurance Co. _____ **Phone** ( ) _____

Insurance Co. Address _____ **City** _____ **State** _____ **Zip** _____

Insurance Identification #_____ **Group #**_____

INSURANCE INFORMATION (Secondary coverage) ☐ NONE

Name of Insured _____ ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT**

Birth date of policy holder: _____/_____/_____ **SSN** _____-_____-_____

Name of employer:_____ **Work phone** ( ) _____

Address _____ **City** _____ **State** _____ **Zip** _____

Insurance Co. _____ **Phone** ( ) _____

Insurance Co. Address _____ **City** _____ **State** _____ **Zip** _____

Insurance Identification #_____ **Group #**_____

CONFIDENTIAL