PRAIRIELANDS CHIROPRACTIC CLINIC, P.C., 300 W. BROADWAY, SUITE 712, COUNCIL BLUFFS, IA 51503 712-256-2561

PATIENT'S FIRST NAME: _____

MIDDLE: _____

LAST: _____

PATIENT'S SOCIAL SECURITY NUMBER: _____

PATIENT'S BIRTH DATE: _____/_____/_____ **PATIENT'S GENDER**: M ☐ F ☐

STREET: _____ **CITY**: _____

STATE: _____ **ZIP CODE:** _____ ***PLEASE CHECK BOX FOR PREFERRED PHONE NUMBER TO CALL.***

☐ **HOME PHONE**: _____ ☐ Check if you would like text messages.

☐ **CELL PHONE**: _____ **SERVICE PROVIDER:** _____

EMAIL ADDRESS: _____

REFERRED BY: _____

EMERGENCY CONTACT:_____ **PHONE:**(_____)_____-_____
PATIENT STATUS: SINGLE ☐ MARRIED ☐ OTHER ☐ _____
EMPLOYMENT/STUDENT STATUS: EMPLOYED ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT ☐
EMPLOYER'S NAME OR SCHOOL NAME: _____

PRIMARY POLICY HOLDER: ☐ Self OR complete below **RELATIONSHIP: ☐ SPOUSE ☐ CHILD ☐ OTHER**

FIRST: _____ **MIDDLE**: _____

LAST: _____ **POLICY HOLDER'S BIRTH DATE**: _____/_____/_____

POLICY HOLDER'S GENDER: M ☐ F ☐ **INSURED'S SSN**: _____

STREET: _____ **CITY**: _____
STATE:_____ **ZIP CODE:** _____ **HOME PHONE**: _____
CELL PHONE: _____

PLEASE CHECK HEALTH TOPICS YOU WOULD LIKE TO LEARN MORE ABOUT.

☐ CLINIC ANNOUNCEMENTS, EVENTS AND 0FFERINGS ☐ STRESS MANAGEMENT ☐ CHILDREN'S HEALTH ISSUES
☐ WOMEN'S HEALTH ISSUES ☐ EXERCISE & FITNESS ☐ DIET & NUTRITION
☐ WELLNESS TOPICS ☐ HEADACHES & NECK PAIN ☐ BACKACHES & SCIATICA

If Applicable: SECONDARY POLICY HOLDER: ☐ Self OR complete below **RELATIONSHIP: ☐ SPOUSE ☐ CHILD ☐ OTHER**

FIRST: _____ **MIDDLE**: _____
LAST: _____ **SECONDARY'S BIRTH DATE**: _____/_____/_____
SECONDARY POLICY HOLDER'S GENDER: M ☐ F ☐ **INSURED'S SSN**: _____
STREET: _____ **CITY**: _____
STATE:_____ **ZIP CODE:** _____ **HOME PHONE**: _____
CELL PHONE: _____

Patient Signature: _____ **DATE**: _____/_____/_____

Parent/Guardian Signature if Patient is a Minor:_____ **DATE**: _____/_____/_____