Full Legal Name _____ Today's Date _____/_____/_____

Male ____ Female ____ Single ____ Married ____ Widow ____ Divorced ____

How you prefer to be addressed _____ Birthdate _____ Social Security # _____-_____-_____

Street Address _____ City _____ State _____ Zip_____

Cell Phone _____ Home Phone _____

E-Mail Address _____

Referred to our office by _____

Emergency Contact Name _____ Phone Number _____

Employer Information

Employer's Name _____ What do you do there? _____

Employer's Address _____

Years with present employer? _____ Work Phone_____ Ok to call you at work? YES NO

Insurance Information Is your current condition the result of an accident/injury? Yes____ No_____ If yes: Work_____ Auto_____ Slip/Fall_____

Primary Insurance Company

Insurance Company Name _____ ID# _____

Insureds Name & Relation _____ Insureds DOB _____ Insureds SS#_____

Ins. Co. Address _____

Ins. Co. Phone Number _____

Secondary Insurance Company

Insurance Company Name _____ ID# _____

Insureds Name & Relation _____ Insureds DOB _____ Insureds SS#_____

Ins. Co. Address _____

Ins. Co. Phone Number _____

Patient Acknowledgement

By my signature, I understand and acknowledge that **Banks Chiropractic**, its Physicians and agents, will treat my condition as they deem necessary through the use of chiropractic manipulative therapy and adjunctive therapies. I also understand that all original documents and original X-rays creased as a result of the performance of examinations will remain the property of **Banks Chiropractic**, its Physicians and agents, will not be held responsible for any undisclosed pre-existing conditions. As the parents, guardian, or parentally authorized agent, I hereby authorize **Banks Chiropractic**, its Physicians and agents, to administer care to this minor.

Signature of Patient/Responsible Party _____ Date_____/_____/_____

Banks Wellness; Scott Banks, DC, IFMCP, PC 755 New York Ave., Suite 308; Huntington, N.Y. 11743; 631-271-0770