Bozeman Chiropractic 15 S. 5th Ave. Bozeman, MT

Patient Information

Full Name: _____
(first name) (middle init) (last name)

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____
(By providing my email address, I authorize Bozeman Chiropractic Clinic to contact me via email)

May we contact you for appointment reminders? ☐Yes ☐No
Preferred contact method: ☐Text ☐Home Phone ☐Cell Phone ☐Email

Date of Birth: _____ /_____ /_____ Height:_____

How did you hear about Bozeman Chiropractic? _____

Emergency Contact: _____

Phone: _____ Relationship: _____

Insurance: Do you intend to pay, or partly pay, with insurance? ☐ Yes ☐ No

Worker's Compensation: Do you intend to file with worker's compensation, or authorize another to file worker's compensation, on your behalf, regarding any injury that may have caused or aggravated the symptoms or condition(s) that you're seeking treatment for? ☐ Yes ☐ No

If yes, please list your employer or authorized representative:_____

By signing below I acknowledge and consent to receive treatment at Bozeman Chiropractic Clinic. I acknowledge treatment may include instrument-assisted adjustment, manual adjustment, instrument-assisted and/or manual massage, distraction, traction, and/or cupping. I am aware that injury due to chiropractic treatment is unlikely though possible. I do not hold Bozeman Chiropractic Clinic, LLC or it's employee(s) responsible for any injury or perceived injury that may result during or after treatment. I acknowledge that a same-day cancellation of an appointment may incur a 20% charge. If providing insurance information, I give my consent for Bozeman Chiropractic Clinic, LLC to share information I have provided on this form, as well as my medical information, with my insurance provider(s).

_____ _____
Signature Date