

Locke Chiropractic and Rehabilitation Center, LLC

173 Jonestown Rd Winston-Salem, NC 27104
336-659-2606

First Name: _____ Last Name: _____ MI: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Street Address and Number: _____

City: _____ State: _____ Zip Code: _____

Mailing Address (if different): _____

Email Address: _____ Age: _____ Date of Birth: _____

Social Security Number: _____ Sex: Male Female Number of Children: _____

Occupation: _____ Employer: _____

Work Status: Full Time/ Part Time **Circle One:** Married Single Widowed Divorced

Driver's License #: _____ State _____

How were you referred to our office? _____

In case of emergency, please contact (include phone number) : _____

Spouse's Name: _____ Spouse's Occupation: _____

Name of Insurance Company (if applicable): _____

Would you like us to file your insurance for you? YES NO

Have you met your deductible (if applicable): YES NO

Name of person responsible for payment: _____

List your family physician, including address and any medications you are currently taking: _____

Have you ever been involved in an automobile accident? (dates& explain) _____

Why are coming to see the Doctor? (list in order of severity) _____

I hereby authorize Locke Chiropractic & Rehabilitation Center to examine me, including x-rays if indicated by my exam, and release my records to anyone I designate. I further authorize treatments deemed necessary by the findings, and wish all my chiropractic records to be held in strict confidence and not to be given to anyone without my written consent. I authorize payment directly to the doctor from my insurance company and I clearly understand that I am totally responsible for payment should my insurance company deny payment, or make payment directly to me. **First day's fees are payable at the time of service.**

By signing your name below, you certify the accuracy of all information contained herein and further certify that you present to this office for evaluation and treatment of a health related condition and for no other purpose.

Signature of patient, or Guardian authorizing care

Date