URGENTCARE CHIROPRACTIC®

CONSULTATION FORM

Alberta Health Care # __/__/__/__/__ - __/__/__/__

Full Name Dr Mr Mrs Ms Miss _____ Birth Date _____ /____/ _____
dd / mm / yy

Address _____

City _____ Province _____ Postal Code _____

Phone (res) (____) _____ Phone (wk) (____) _____ Phone (cell) (____) _____

Email _____!!!!

Employer _____ Occupation _____

Age _____ Height _____ Weight _____

Marital Status _____ Name of Spouse _____ Number of Children _____

If under 18 name of responsible party _____

Your major complaint or symptom is _____

Previous surgery, illness or accidents _____

Name of family physician _____

Have you had previous chiropractic care? _____ Doctor's Name _____ Last Visit _____

Who referred you or how did you hear about our clinic? (circle one and please specify name)

Facebook Internet Physician Friend/Family _____
name

Is this a Worker's Compensation case? _____ has your employer been notified? _____

Is this an Auto Accident case? _____ Date of accident _____

I realize that Alberta Health Care Insurance Commission will not pay the Doctor's fee schedule and that I am personally responsible for payment. I further understand that I am responsible to submit my own claim through my insurance company if I have personal coverage.

If this is an auto accident case I understand that I am responsible for all debts incurred at this clinic which are due and payable after each visit unless special arrangements have been made with my insurance company.

_____ _____
Signature (signifying the above to be true) Date