Welcome to Life Line chiropractic & massage

Patient Intake Form

Please print legibly while answering the following questions.

Name	Date of Birth/ Age
Address	Home/Cell Phone
City	State/Zip
Employer	Marital Status
Social Security #	Spouse/ Partner/Significant Other:
Do you have health insurance you would like us to file? If **yes**, please name your carrier. If **no**, who is responsible for payment on your bill?	Have you been to a Chiropractor before? If yes, please name your previous Chiropractor.

Please share your reason for visiting us today. _____

Who may we thank for referring you to our office? _____

We send emails containing relevant health articles, wellness tips, promotions and savings to use in the office.

Would you like to be put on our list to receive our newsletter? (your email will not be shared or used for any other purpose)

Yes ____ Email-_____

No ____

All services performed shall be paid for at the time of service, unless arrangements have been made. If we are billing your insurable be aware that having insurance is NOT A GUARANTEE OF PAYMENT nor does it GUARANTEE FULL PAYMENT of all services performed. By signing you understand and agree that the final outcome of the bill is your responsibility and within 30 days of receipt of billing statements your account will be paid in full.

Patient/ Guardian Signature: _____ Date: _____