Kluver Chiropractic & Wellness

Patient Introduction

Your Name: _____/_____/_____

First Middle Initial Last

Your Street Address_____

City_____State_____ Zip Code_____

Cell/Home Phone_____Alt. Phone_____

Birth Date___/___/_____ Gender ____ Marital Status_____

Email_____ Referred by_____

Employer_____ Occupation_____

Emergency Contact_____Phone_____

Circle whichever best applies: Self pay/Health Insurance/
Auto Accident/Work Comp/

Please understand that any fees incurred at Kluver Chiropractic that will not be paid by insurance/third party, will be the patient's personal responsibility.

I give my consent to have the doctor take an x-ray he/she deems appropriate to better understand my problem and monitor my progress.

Signature:_____ Date ___/___/_____