Moua-Lor Chiropractic & Acupuncture, P.A.
1819 Lowry Ave North, Mpls, MN 55411
Phone: (612) 529-0202 Fax: (612) 521-1445

PLEASE PRINT: DATE: _____/_____/_____

NAME (First, middle, last):_____

STREET ADDRESS: _____

CITY/STATE/ZIP: _____

SEX: ☐ FEMALE ☐ MALE

CELL PHONE: (_____)_____

HOME PHONE: (_____)_____

WORK PHONE: (_____)_____

BIRTHDATE: _____/_____/_____

SOCIAL SECURITY NUMBER: _____-_____-_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPERATED

EMPLOYMENT STATUS: ☐ EMPLOYED ☐ UNEMPLOYED ☐ RETIRED ☐ HOMEMAKER
☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT

HISTORY OF PRESENT ILLNESS/INJURY: ☐ Car Collision ☐ Work Injury ☐ Slip and Fall

☐ Other_____ Date of Injury: _____/_____/_____

EMPLOYMENT INFORMATION:

_____ _____
(Occupation) (Employer Name)

_____ _____
(Employer Address) (City, State, Zip Code)

SPOUSE INFORMATION (if applicable):

_____ ____/____/____
(First, Middle, Last Name) (Date of Birth)

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EMERGENCY CONTACT INFORMATION:

(First, Middle, Last Name)	(Phone Number)	(Relationship to Patient)

INSURANCE INFORMATION:

(Name of Insured)	(Date of Birth)	(Relationship to Patient)

(Insurance Company Name)	(Claim Number)

CONSENT TO TREATMENT:
I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations, and treatment.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:
I agree to pay all charges for medical and health care services not covered by my insurance company.

I certify that I have read this form and understand its contents.

(Print patient name)

(Patient or other legally authorized person signature)	(Date)