SANDMAN CHIROPRACTIC

Tapan Joshi, D.C.
107 WEST LAKE STREET, SUITE 103 BLOOMINGDALE, IL 60108 (630)351-0222

WELCOME TO OUR CLINIC

All About You

Name:_____ SSN:____-____-____ Date:____/____/_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone (_____)_____-_____ Cell Phone (_____)_____-_____ Date of Birth:____/____/_____

Email address: _____

Sex (circle): M/F Marital Status (circle): SINGLE/MARRIED/SEPARATED/DIVORCED/WIDOWED

Whom may we thank for referring you to our clinic?_____

Employer Name:_____ Occupation:_____

Work Address:_____ City:_____ State:_____ Zip:_____

Work Phone (_____)_____-_____ How long have you been employed here? _____years _____months

What do your daily work habits include (circle): sitting/standing/bending/light labor/heavy labor/clerical

If patient is under the age of 18, please fill out the following section:

Name of Guardian:_____ Relation to patient:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Home Phone: (_____)_____-_____ Work Phone: (_____)_____-_____

Insurance Information

Insurance Company Name:_____ Phone: (_____)_____-_____

Address:_____ City:_____ State:_____ Zip:_____

Name of Insured:_____ Relation to you:_____ Phone: (_____)_____-_____

Policy # _____ Group # _____ Date of Birth of Insured: ___/___/____

SSN of Insured: ___-___-____

Do you have any secondary /supplemental insurance (circle): Y/N

If yes, Name/Address/Phone # of Insurance Company:_____

In Event of an Emergency

Contact:_____ Relation:_____ Phone: (_____)_____-_____

Primary-Care Physician's Name:_____ Phone: (_____)_____-_____

_____ ____/____/_____

Signature of Patient (or Guardian if patient is under age 18) **Date**