Barcode/Z #:

Confidential Patient Information

Name: ______________________________ **Date:** ____________________

Address:
STREET ____
CITY ______________ STATE ____________ ZIP __________

Birth date____/____/____ Age: ______ Sex: ☐ Male ☐ Female
Marital Status: S/M/W/D (please circle) # of children: ________

How did you hear about us? __________________ Previous Chiropractic Care? ☐ Yes ☐ No

Occupation: __________________ Employer: ________________________

Home ( ) ___________ Work ( ) ___________
Mobile ( ) ___________ Email: ________________
In case of emergency, please contact:
Name: ______________ Phone number ( ) __________
Relationship: ______________
Address: __________________

Financial Agreement

I, the undersigned comply and understand that I am responsible for payment of co pays or deductibles in full at the time services are provided. Payments for Clyne Chiropractic & Wellness may be made in the form of cash, check, or credit card. Checks for Clyne Chiropractic & Wellness may be made payable to Clyne Chiropractic & Wellness or Dr. Clyne.

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RESPONSIBLE PARTY SIGNATURE (SIGNATURE OF LEGAL GUARDIAN IF UNDER 18)

24 hour Cancellation Policy

I, the undersigned comply and understand that I am responsible for cancelling an appointment 24 hours in advanced. I understand and comply with a charge of $20 if I cancel my appointment within 4 hours of the appointment time or do not show up.
I permit Clyne Chiropractic & Wellness to charge my card on file.

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RESPONSIBLE PARTY SIGNATURE (SIGNATURE OF LEGAL GUARDIAN IF UNDER 18)