CONFIDENTIAL HEALTH INFORMATION

Dukes Chiropractic Health Clinic, P.A. 2401 Walden Woods Dr. Plant City, FL 33566 813-752-2524 813-754-4967 (Fax)

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy standards. Please print clearly.

Today's Date (MM/DD/YYYY)	Have y ○ No	ou consulted a chiropractor befor O Yes When?	e?	Patient Number (office use only)
Whom may we thank for referring you?		*	If so, whom	?
Your Last Name		Your Social Security Number	Birth Date (MM/DD/YYYY)	Age
Your First Name	8	Your Middle Name (or Initial)	Gender ○ Male ○ Female	Race
Address			Marital Status ○ Married ○ Single ○ Divorced	Ethnicity
City	State/Province	ZIP/Postal Code	○ Widowed ○ Separated	Preferred Language
Home Phone	Cell Phone	2	Spouse's Name	
Email Address			Child's Name and Age	
Emergency Contact	Emergency Cont	act's Phone	Child's Name and Age	
Your Occupation	44.0		Child's Name and Age	
Your Employer			Work Phone	
Address			May we contact you at work	° CO
City	State/Province	ZIP/Postal Code	Preferred method of contac	
Primary Care Provider's Name			○Work Phone ○Email	E E
Insurance Carrier		Policy Number		
Insured's Last Name	16 20	Birth Date (MM/DD/YYYY)	Who carries this policy? Self Spouse Paren	HEAL
Insured's First Name	Insured's Middle	e Name (or Initial)	Coposito Craton	불
Insured's Employer			, °	TH INFORMATION
Address				X
City	State/Province	ZIP/Postal Code	Employer's Phone	

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	○ An i	nterest in: O Wellness O	Other					
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Throbbing	\\\\\	\ J L/	Homeopati	hic remed	ies O Chiropract	ic Other		st 8
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Past Personal, Family Please identify your past he	and Social History ealth history, including ac	cidents, injuries, illnesses a	nd treatments. Please comp	olete each section fully.			
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Water intake

Hobbies: .

O Daily O Weekly How much?_

PAG

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