



CARLSBAD VILLAGE CHIROPRACTIC  
LIVE A BETTER LIFE

**New Patient Intake Form**

Date \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Apt. # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

E-Mail \_\_\_\_\_ Referred By \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ SSN# \_\_\_\_\_

Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Marital: M S W D How many Children? \_\_\_\_\_

Occupation (if dependent list parent's occupation) \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Office Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

PAYMENT IS EXPECTED AT THE TIME OF VISIT!     Cash    Check    Visa/MC

Person responsible for payment

Name \_\_\_\_\_ Phone \_\_\_\_\_ Other \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Are you insured?    YES    NO   Insurance Company \_\_\_\_\_

**CONSENT TO TREATMENT OF MINOR CHILD**

I hereby authorize Dr. Wilkie/Dr. Cherry to administer chiropractic care as deemed necessary to my (circle one) son/daughter \_\_\_\_\_

Name of Child

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent or Legal Guardian