

PATIENT INFORMATION

Dr. T.J. McKay, D.C.
Dr. K.B. Jenkins, D.C.

Date _____

Name _____ E-mail Address _____

Address _____

Home Phone # _____ Business phone _____ Postal Code _____

Occupation or Profession _____ Date of Birth ____D____M____Y

Marital Status S M W D Common-law Spouses name _____

Previous Chiropractic Care Y__ N__ By Whom _____ Last Seen _____

Medical Practitioner _____ Last Seen _____

Alberta Health Care Number: / / / / / / / / / / / / / / / /

Do you have Private Health Insurance? Y__ N__ Name of Company _____

Who your referred you to this office? _____

Have you ever had any falls, accidents, or injuries? Y__ N__ If yes, please explain _____

Have you ever had surgery? Y__ N__ If yes, please explain and give dates _____

Medication presently taking _____

Purpose of visit / primary complaints _____

Do you have any health problems that you think chiropractic cannot help? _____

I clearly understand and agree that all services rendered to me, that are not covered by Alberta health care or WCB, are charged directly to my account, and that I am responsible for payment of services as they are performed.

Signed _____