



● **ADDITIONAL INFORMATION**

E-mail Address \_\_\_\_\_ (quarterly newsletter & scheduled events)

Do you check your e-mail Daily\_\_\_\_ Weekly\_\_\_\_ Monthly\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Number\_\_\_\_\_

If you are under 18 years of age, please provide name of responsible party \_\_\_\_\_

Name of family physician\_\_\_\_\_

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● **INSURANCE**

Is the condition due to a work injury?                      Y or N                      Date of  
injury\_\_\_\_\_\*

Is the condition due to an auto accident?                      Y or N                      Date of  
injury\_\_\_\_\_\*

**\*(IF YES SEE FRONT DESK)**

Name of Insured\_\_\_\_\_ Contract # \_\_\_\_\_

Social Security Number\_\_\_\_\_ Birth date \_\_\_\_\_

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● **WOMEN ONLY**

To ensure that X-Ray procedures are not performed unknowingly on a pregnant patient, it is asked that you initial the correct statement below:

There is a possibility that I **MAY BE** (or) **I AM** pregnant.

\_\_\_\_\_  
Initials                      Due Date                      Date

I am **NOT** pregnant and I give permission to perform X-Ray procedures.

\_\_\_\_\_  
Initials                      Date

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● **PRIVACY NOTICE CONFIRMATION**

I have read and received a copy of the Maillette Family Chiropractic, P.C. Privacy Notice.

\_\_\_\_\_  
Patient Signature                      Date

\_\_\_\_\_  
Guardian/Parent Signature Authorizing Care                      Date