Sauk Prairie Chiropractic, LLC
590 Fourth Street
Prairie Du Sac, WI 53578

Patient Information

Today's Date: _____

Name: _____

Address: _____

City/State: _____ Zip: _____

Home Phone Number: ☐same as cell (_____) _____

Cell Phone Number: (_____) _____

E-mail: _____ Preferred Contact Method: _____

Preferred Language: _____ Date Of Birth: _____ Age: _____

Race (**Circle One**): African American, American Indian, Asian, Black, Caucasian, Hispanic, Other

Ethnicity (**Circle One**): American Indian, Alaska Native, Asian, Black/African American, Hispanic

Native Hawaiian, White, Other:

Employer: _____

Address of Employment: _____

City/State: _____Zip: _____

Work Phone Number: _____

Occupation: _____ Full-time Part-time

(Please indicate if a student) (Circle if full-time or part-time student/work status)

INSURANCE POLICYHOLDER INFORMATION (**If other than patient**)

Policyholder's Name: _____

Date of Birth: _____ Relationship to Patient: _____

Policyholder's Employer: _____

Parent/Guardian's Signature (under 18 years of age):_____

Patient's Signature: _____