

PATIENT INFORMATION

Dr. K.B. Jenkins, D.C.

Date _____

Dr. S. Bounket, D.C.

Dr. J.S. Thomas, D.C.

E-mail Address: _____

Please add me to the mailing list for appointment reminders,
important health information, clinic updates and newsletters

Name: _____

Address: _____ City: _____ Postal Code: _____

Primary Phone: _____ Alternate Phone: _____

Occupation or Profession: _____ Date of Birth: (DD/MM/YY) _____

Marital Status: S M W D Common-law Spouse Name: _____ Number of children: _____

Emergency Contact (Name & Phone): _____

Previous Chiropractic Care: Y N By Whom: _____ Last Seen: _____

Medical Practitioner: _____ Last Seen & Why: _____

Alberta Health Care #: _____ Gender: M / F / Other

Private Health Insurance? Y N Name of Company: _____

Who referred you to this office? _____

Is this a work related injury (WCB)? Y N Has your employer been notified? Y N

Is this a Motor Vehicle Accident (MVA)? Y N On what date did the accident occur? _____

Have you ever had any falls, accidents, or injuries (including MVA/WCB)? Y N If yes, please explain: _____

Have you ever had surgery? Y N If yes, please explain and give dates: _____

Please list any previous or current illnesses: _____

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 insurance or WCB, are charged directly to my account, and that I am responsible for payment of services as they are performed.

Patient Signature: _____