

PATIENT INFORMATION SHEET



Kennard Chiropractic and Physical Therapy
650 Ritchie Highway, Suite 106
Severna Park, MD 21146
410-421-5544

We Care

This information is confidential and will not be shared.
Please complete entire form

Date: _____

Patient Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Address: _____ City: _____ State: ____ Zip: _____

Social Sec #: _____ - _____ - _____ Date of Birth: ____ / ____ / ____

Sex ____ Marital Status: ____M ____Single ____Other

Insured's Name: _____ Relationship to Insured: _____

Insured's Employer: _____

Insured's Date of Birth: ____ / ____ / ____ Insured's Social Sec #: _____ - _____ - _____

Insurance Company: _____ Policy #: _____ Group #: _____

How did you hear about us? _____

Referred By: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Major complaint: _____

Most recent occurrence: _____

Job Related (Y/N) ____ Auto Related (Y/N) ____ Date of Accident/Injury: _____

Other doctors seen for this condition: _____ Phone: _____

_____ Phone: _____

Have you seen a Chiropractor before? (Y/N) ____ Doctor's Name: _____

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____