**Dr. Jeff Echols, DC**

**NEW PATIENT INFORMATION FORM**

Please print clearly:

Name Date

Address Apt.#

City State ZIP

Shipping Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you find out about us? :**

Occupation Employer

Date of Birth Age \_\_\_\_ Sex: M/F Height \_\_\_\_\_ Weight \_\_\_\_\_

Overall health (circle one): Excellent / Good / Fair / Poor / Other:

Chief complaint (reason you are here): (use separate sheet if more room needed)

Previous treatments for this complaint

Other complaints or problems: (use separate sheet if needed)

Current medications/drugs being taken: (use separate sheet if needed)

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

Nutritional supplements you are taking:

**How can we best serve you?**

 \_\_\_Get rid of the symptoms, ONLY.

\_\_\_Get rid of the symptoms, AND then correct the underlying problem so that it has less chance of returning.

\_\_\_Get rid of the symptoms, correct the problem, AND also talk to me about supplements and nutrition so that I can be as healthy as possible and get the most out of life.

*I understand and agree that regardless of my insurance status I am ultimately responsible for the balance of my account for any professional services rendered. I have read all of the information on these forms and have completed the answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent (if minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

My credit card will be charged for any office visit not cancelled within 24 hours. The fee will not be deducted from any prepaid amount, as prepaid amounts are strictly for care. \_\_\_\_\_\_Initial