

**Coastal Chiropractic & Wellness Center
Dr. Karen Bannon-Boisvert, D.C.**

Patient Introduction Form

Name (First, M, Last) _____	
Nickname (if preferred) _____	Sex (M/F) ____ Marital Status (M/S/D/W) ____
Date of Birth ____/____/____	Age ____

Home Phone _____	Cell Phone _____
Work Phone _____	Email _____
Address _____	
City _____	State ____ Zip Code _____

Occupation _____	Employer _____
Insurance Company _____	Social Sec. # ____ - ____ - ____
Relationship to insured: <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Other	

Major Complaint _____
Referred by _____

*If you are visiting the doctor for injuries sustained from an auto or work related accident please inform the front desk.
If you have health insurance coverage please bring your insurance card to your appointment and present it to the front desk.*

IT IS USUAL AND CUSTOMARY TO PAY FOR SERVICES AS RENDERED UNLESS OTHERWISE ARRANGED.