PHYSICAL DIMENSIONS
CHIROPRACTIC, PHYSICAL THERAPY, SPORTS MEDICINE
www.physicaldimensionsihg.com

INVERNESS : 303.925.1050
FAX: 888.808.8236
INFO@PHYSICALDIMENSIONSIHG.COM
88 INVERNESS CIR E., A-106 ENGLEWOOD,CO 80112

Thank you for choosing our clinic for your health care needs. We are very happy you are here. In order to serve you to the best of our ability, we will need you to complete the following patient information and answer all questions on the subsequent questionnaires to best of your ability. We use this information to know you better and to file insurance for you, if applicable. Please be patient in providing us all the necessary information, we do not like paperwork anymore than you do. We want you to reach your health care goals, so please be complete with your answers. **Again, Thank You!**

PATIENT INFORMATION

Date:__________

Patient Name:_______________________________

Address:__________________________________

____
City ST ZIP

Sex: M F Age:______ Birthdate:___/___/___

___Single ___Married ___Divorced ___Separated ___Widowed

Occupation:________________________________

Employer:_________________________________

Spouse's Name:____________________________

Spouse Occupation:_________________________

Spouse's Employer:_________________________

Provide Name & Clinic of Your Primary Care Physician:

Doctor:___________________________________

Clinic:____________________________________

How Did You Hear About Us?

__Personal Referral Name:_______________________

__Internet/Clinic Website: Where:__________________

__Social Media Where:___________________________

CONTACT INFORMATION

Phone:

Cell #: (_____)_____-_________

Carrier:_____________________
(For clinic text appointment reminders)

Home #: (_____)_____-________

Work #: (_____)_____-_________

E-mail:_______________________________________

Best Time/Place to reach you_______________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name____________________ Best #: (___)____-______

FINANCIAL INFORMATION

Type of Account:

AUTO:____ **INSURANCE:**____ **SELF PAY:**____

Who is Responsible for this account?___________________

Relationship to patient (Self, Spouse, etc.)________________

Insurance Company:_______________________________

Subscriber's Name:_______________________________

Birthdate:___/___/____ SS#:______________________