Cousineau Chiropractic Life Center, P.C.

WELCOME TO OUR OFFICE!

It is an honor to be of service to you.

Please complete the following confidential patient health record.

Patient Information

Date: _____ Patient ID Number _____

Name: _____ Date of Birth: ___/___/___ ☐ Male ☐ Female

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

Home Phone _____ Cell Phone _____

Work Phone _____ Your Employer _____

Have you ever been to a chiropractor? ☐ Yes ☐ No If yes, when was your last visit?_____

Your Status:
- ☐ Employed
- ☐ Retired
- ☐ Full Time Student

Referral:
- ☐ Mail
- ☐ Newspaper/TV
- ☐ Phone Book
- ☐ Speaking Engagement
- ☐ Expo
- ☐ Former Patient
- ☐ Walk In
- ☐ Patient/Friend

Whom may we thank for referring you to us?

_____

Your Status:
- ☐ Married
- ☐ Single
- ☐ Widowed

I am here to see Dr.: ☐ Henry J. Cousineau, D.C. ☐ Nicole R. Cousineau, D.C.
☐ Kristin J. Cousineau, D.C ☐ Richard J. Stanley, D.C.
☐ _____

Insurance Information

Name of Primary Insurance Carrier _____

Insured's Name & Address (if other than self): _____

Patient Relationship to the Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Insured's Birthdate (if other than self): _____

Insured's Employer_____ Retired? Y N

DO YOU HAVE A HEALTH SAVINGS ACCOUNT? Yes___ No___

☐ Flex Spend Account ☐ Health Savings Account (HSA) ☐ EHIM ☐ MEBS (Messa)

Please provide us with any additional information we may need.

Name of Secondary Insurance Carrier_____

Insured's Name & Address (if other than self): _____

Patient Relationship to the Insured: ☐ Self ☐ Spouse ☐ Dependent ☐ Other

Insured's Birthdate (if other than self): _____

Insured's Employer_____ Retired? Y N