PERTH
Family Health Centre
33 Lewis Street, Perth ON K7H 2R4
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info@perthfamilyhealth.com www.perthfamilyhealth.com

Personal Information

Collected on behalf of Perth Chiropractic.

Today's Date _____
(DD/MM/YYYY)

Your Given Name _____ *Your Last Name* _____
Do you have a preferred name? _____
*Date of Birth*_____ *Age* _____
(DD/MM/YYYY)

Home Address _____

Town/City _____ *Postal Code* _____

Home Phone # _____*Cell Phone #*_____*Work #*_____
(Include area code for all phone numbers)
*Email Address*_____
Please read and sign the consent form provided if you wish to communicate by email at any time during your care.
Would you like to receive newsletters? Yes ◯ No ◯ (By selecting yes, you will receive the newsletters by email)

Your place of employment _____ *Occupation* _____

Present Medical Doctor _____
We routinely inform family physicians of your care; do you wish for us to communicate with your M.D.? Yes ◯ No ◯

Tell us how you heard about our office.
◯ *Family Member or friend*
(Their name if you wish to provide) _____

◯ *Referred from a M.D., Massage Therapist or other*
(Please provide their name) _____
(We do not send updates to referring professionals)
Have you had previous Chiropractic Care? Yes ◯ No ◯
If yes, please provide approximate year of your last visit _____

"Helping People Lead Better and Easier Lives"