FAYE CHIROPRACTIC
10801 National Blvd., Suite 340
Los Angeles, CA 90064
310) 470-1225

Heather B. Faye, D.C.

PATIENT INFORMATION FORM

Date: _____ /_____ /_____

New Patient: _____ Previous Patient w/ new injury or case?:_____Weight:_____Height:_____

First Name: _____ M.I. ____ Last Name: _____

Birthdate: ____ /____ /____ Current Age: ___ Marital Status: S___ M___ W___ D___

Gender Identity: _____ Prefer not to answer (__) Pronouns: _____

Social Security #:____ - ____ - ____

Home Address: _____City: _____ ST:_____ZIP:_____

Home Phone: _____ Mobile Phone:_____

Email:_____

Employer:_____ Work Phone:_____

Person responsible for this account:_____ Referred by:_____

Date & Time illness/injury occurred?:_____How did it happen?:_____

If Auto Accident, Auto Ins Co.:_____ Claim #: _____

Adjuster Name:_____

Did you see any other doctor(s) for this illness/injury?:

Yes (__) No (__) If yes, whom?_____ Phone: _____

Did you have x-rays taken? Yes (__) No (__)

Are you, or do you think you might be, pregnant? Yes (__) No (__)

Cause of complaint:

Auto Accident (__) Work Injury (___) Other Accident/Injury (___) Illness (___) Congenital (___) Unknown (___)

Are you interested in total wellness? Yes (__) No (__)

_____ _____
Patient Signature **Date**

_____ _____
Parent Signature if treatment is for a minor under 18 years of age. **Date**