Dr. Tyler T. Taylor
CHIROPRACTIC
445 Rosewood Avenue, Suite A ▪ Camarillo, CA 93010
(805) 484-8930

Please fill out the following form in as much detail as possible.

(Please Print) Date _____

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office/Cell Phone _____

E-mail Address _____

Age _____ Date of Birth _____ Occupation _____

Sex: M ❑ F ❑ Social security number (for billing purposes) _____

Referred By _____

Employer _____

Marital Status: S ❑ W ❑ D ❑ Children ____ Name of Spouse _____

Have you ever had chiropractic care before? _____

Major complaints and symptoms – please be as specific as you can. Ask the doctor or nurse for help if you need assistance in filling out this section.

_____

_____

_____

How do you believe your problem (pain) began?

_____

_____

_____

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and that all services rendered me are charges directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE _____