CHIROWELL
LIVE WELL

Date _____

Name _____

DOB ____/____/____

Phone (Home or Work) _____ Cell _____

Address _____
Number & Street Apt # City State Zip

Primary Email Address _____

Name you prefer to be called: _____

☐ Single ☐ Married/Partnered

# of Children ____ How many at home? _____ Names & ages: _____

Employed? ☐ Yes ☐ No Profession and Employer? _____

Which medical practitioners or specialists are you currently seeing? _____

Which holistic practitioners? _____

Have you ever been to a chiropractor before? ☐ Yes ☐ No Approximate date of last visit ____/____/____

If Yes, how long did you receive care? _____

Have you ever been told you have any issues in your spine or nerve system? ☐ Yes ☐No

If yes, what? _____

Whom may we thank for referring you to Dr Jae? _____

If not through a personal or MD referral, how did you find Dr. Jae?

Notice of Privacy Practices
Acknowledgment Form

We will never share your personal or private information with others.

We may only disclose information about you in the following ways:

- To another health-care provider, hospital or facility if they request it in order to assist them in caring for you.
- To an insurance carrier or employer if they are possibly responsible for payment or reimbursement of services.
- If you are not available to receive an appointment reminder, a message may be left on your answering machine or with a person in your household or at work. We may also send you correspondence by email.

My signature acknowledges I have read this notice, understand it and agree with the policies explained.

Name (Print) _____

Signed _____ Date ____/____/____