METCALF CHIROPRATIC HEALTH CENTER

15435 Main St NE, Suite 101 PO Box 507 Duvall, WA 98019 ph. 425-844-6428 fax. 425-788-7824
Dr. Jeffrey P. Metcalf

Welcome To Our Office

Name ____ I prefer to be called __________________
First MI Last

Home Address: ____
Street City Zip

Mailing Address: ____
Street City Zip

Phone: ( )____________________ ( )____________________( )____________________
Home Cell Work

E-mail: ____

Birth Date: _____/_____/______ Age: ______ Male / Female Marital Status S M W D

Social Security #: ___________________________ Spouse's Name: ______________________________

Children (please list - names, ages & sexes)

____

Employer: _______________________________ Type of Work: __________________________________

Emergency Contact Information

Name: ______________________ Relation: ______________________ Phone: ____________________

Person Responsible for Account, If Other Than Yourself

Name: __________________________ Relation: ______________________ D.O.B.: _____/_____/_____

Billing Address: ____
Street City Zip

Phone: ( )____________________ ( )____________________( )____________________
Home Cell Work

Employer: ____ S.S. #: _____________________________

How did you hear about our office: ☐ Dr. Referral ☐ Friend/Family ☐ Newspaper ☐ Flyer
☐ Insurance Company ☐ Walk In ☐ Internet ☐ Other: ____________________________

Whom may we thank for referring you: ____

Our office policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the Doctor. I authorize the provider to release any information required to process any insurance claims. I have read and agree that the above stated information is correct.

____ ___________________________
Signature Date