



# METCALF CHIROPRACTIC HEALTH CENTER

PO Box 507, 15315 1<sup>st</sup> Ave NE Suite 5, Duvall, WA 98019 Ph.425-844-6428

**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: \_\_\_\_\_

Billing Address: \_\_\_\_\_  
  Street  City  Zip

Phone: \_\_\_\_\_  
                    ( )  ( )  ( )  
                    Home  Cell  Work

Employer: \_\_\_\_\_ S.S. #: \_\_\_\_\_

### Insurance Information

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

Policy #: \_\_\_\_\_ Policy #: \_\_\_\_\_

How did you hear about our office: \_\_\_\_\_

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