



Grayhawk Family Chiropractic
7900 E Thompson Peak Pkwy --- #105
Scottsdale, AZ 85255
p 480.247.9063
f 481.247.9974
grayhawkchiro.medicfusion.com

Patient: _____

Patient Profile

Personal Information

Full Name: _____ *Jr / Sr*
Last First M.I.

Address: _____
Street Address Apartment/Unit #

City State ZIP Code

Primary Phone: _____ *H / M / B* Alternate Phone: _____ *H / M / B*

Birth Date: _____ / _____ / _____

Social Security Number #: _____ - _____ - _____

Gender: Male Female

Race: American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White Declined Unknown/Unavailable
 Other _____

Ethnicity: Hispanic or Latino Not Hispanic or Latino Declined Unknown/Unavailable

Prim. Language: Arabic Chinese English French German Greek Hebrew Italian
 Japanese Korean Spanish Vietnamese Declined Unknown/Unavailable
 Other _____

Email Address: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Time Zone: _____

Does your time zone participate in Daylight Savings Time? Yes No

Marital Status: Single Married Widowed Divorced

Do you have any dependents? Yes No

Are you a full-time student? Yes No

Health Insurance? Yes No

Responsible Party: You Other (parent, spouse, etc.) _____

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Physician Form

Physician Information

Type of Physician: Chiropractic Family Specialist

Physician Name: _____
First Name Last Name

Address: _____
Street Address Unit #

City State ZIP Code

Phone: _____ Ext. _____ Fax: _____

Email Address: _____

Type of Physician: Chiropractic Family Specialist

Physician Name: _____
First Name Last Name

Address: _____
Street Address Unit #

City State ZIP Code

Phone: _____ Ext. _____ Fax: _____

Email Address: _____

Type of Physician: Chiropractic Family Specialist

Physician Name: _____
First Name Last Name

Address: _____
Street Address Unit #

City State ZIP Code

Phone: _____ Ext. _____ Fax: _____

Email Address: _____

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Employer Form

Employer Information

Your Employment Status: Full Time Part Time Contract Not Employed Retired Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apartment/Unit #*

_____ _____
City *State* *ZIP Code*

Employer Phone: _____ Ext. _____ Fax: _____

Start Date: _____ / _____ / _____ End Date: (If you are no longer working here.) _____ / _____ / _____

Your Employment Status: Full Time Part Time Contract Not Employed Retired Student

Occupation or Title: _____

Employer Name: _____

Employer Address: _____
Street Address *Apartment/Unit #*

_____ _____
City *State* *ZIP Code*

Employer Phone: _____ Ext. _____ Fax: _____

Start Date: _____ / _____ / _____ End Date: (If you are no longer working here.) _____ / _____ / _____

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Responsible Party Form

Responsible Party Information

Relationship to You: _____

Full Name: _____
First *M.I.* *Last*

Same as your address? Yes No

Address: _____
Street Address *Apartment/Unit #*

City *State* *ZIP Code*

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