Welcome to Dr. Allison Zak D.C. LLC's Office

New Patient Form

Please provide us with the following confidential information. This information will be a part of your permanent records.

Personal Information

Today's Date: ____/____/_____ **Date Of Birth:** _____

Patient Name: First_____MI___Last_____ **Sex:** □M □F

Parent/Guardian (if patient is a minor): _____ **Relationship to patient:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Cell Phone: _____ **Work Phone :** _____

Home Phone: _____

Please check cell carrier below ONLY if you would like to receive appointment reminders via text:

□ **AT&T** □ **Sprint** □ **T-Mobile** □ **Verizon** □ **Other**_____

Employer: _____ **Occupation:** _____

Marital Status: □M □S □D □W **Spouse's Name:** _____

Primary Physician: _____ **How did you hear about us:** _____

Emergency Contact/Relationship: _____ **Phone :** _____

Primary Language: □ English □ Spanish □ Other _____

Race: □ White □ Asian □ African American □ American Indian □ Declined to Answer

Ethnicity: □ Non-Hispanic/Latino □ Hispanic/Latino □ Declined to Answer

Authorization for Treatment

For All Patients

I hereby authorize Allison Zak, D.C. LLC to treat my condition as deemed appropriate through the use of chiropractic manipulation, nutritional therapy, physiotherapy and/or other natural, drug-free methods. I choose to be an active participant in my treatment and realize that I am responsible for my health choices.

Signature: _____ Date: ____/____/_____

Parent/Guardian Name: (Please Print) _____