Vitality Life Chiropractic, LLC

4445 W 77th Street, Ste 221
Edina, MN 55435
Office: 952-923-4003 Fax: 800-516-1986

Today's Date:_____ Name:_____

Age:_____ Birthdate:_____

Home Address:_____ City/State/Zip:_____

Home Phone:_____ Work Phone:_____ Cellular/Pager:_____

Permission to Text? **Yes or No**

E-mail:_____ Occupation: _____

Place of Employment: _____ Phone: _____

Name of spouse/significant other: _____ Phone:_____

Who may we contact in case of emergency? _____Phone:_____

Primary physician:_____Phone:_____

Nearest relative not living with you: _____Phone:_____

Who may we thank for referring you to us? _____Phone:_____

By signing I agree to the following: I have read and I have completed the above answers. I certify this information is true and correct to the best of my knowledge. I give permission to Vitality Life Chiropractic, LLC and its representative's to communicate with me via the contact information above.

Date:_____ _____
Patient Signature

Date:_____ _____
Parent or Guardian (if minor)

_____-_____-_____
Social Security Number

Internal Administrative Document Information is Confidential