

FOWLER CHIROPRACTIC
7455 W. TWIN PEAKS STE 111
TUCSON, AZ 85743

HIPPA requires us to acquire detailed information from our patients. HIPPA requires for all new patients to have a picture on file; please not your picture will be taken for office purposes only

First Name:_____ Last Name:_____

Height:_____ Weight:_____

Race:_____ Ethnicity:_____

Blood Pressure:_____

Smoke: r YES NO FORMER NEVER

Were you referred by anyone? YES NO

Who can we thank for the referral? _____

Patient Signature

Date