UPDATED CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files

Dr. Michael J. Cleaver, D.C.

Today's Date (MM/DD/YYYY)

Age **Gender** ◯Male ◯Female

Birth Date (MM/DD/YYYY)

Your Last Name

Your First Name **Your Middle Name (or Initial)**

Address

City **State** **Zip**

Home Phone **Cell Phone**

Email Address

Emergency Contact **Emergency Contact's Phone**

Your Occupation

Your Employer

Address

City **State** **Zip**

Primary Care Provider's Name

Insurance Carrier **Policy Number**

Insured's Last name **Birth Date (DD/MM/YYYY)**

Insured's First Name **Insured's Middle Name/Initial**

Insured's Employer

Address

City **State** **Zip**

Smoking Status (age 13 and over)

◯ Never a smoker ◯ Former Smoker
◯ Current Every Day Smoker ◯ Light Smoker
◯ Current Some Day Smoker ◯ Heavy Smoker

Marital Status

◯ Married ◯ Single
◯ Divorced ◯ Separated
◯ Widowed

Preferred Language

Spouse's Name

Child's Name and Age

Child's Name and Age

Child's Name and Age

Work Phone

May we contact you at work?

◯ Yes ◯ No

Preferred method of contact?

◯ Home Phone ◯ Cell Phone
◯ Work Phone ◯ Email

Who carries this policy?

◯ Self ◯ Spouse ◯ Parent

Employer's Phone