

**MARK E. COTNEY, D.C., P.C.**  
**Thomaston Chiropractic Clinic**  
101 North Green Street  
Thomaston, Ga 30286  
Telephone 706-647-2225 Fax 706-648-2153

**APPLICATION OF TREATMENT**

Please check the type of care desired: \_\_\_\_\_ Temporary Relief \_\_\_\_\_ Lasting Correction

DATE \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone# \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

Ages of Children \_\_\_\_\_ Whom may we thank for referring you \_\_\_\_\_

Employer Name \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Last name \_\_\_\_\_ - First Name \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Home Phone # \_\_\_\_\_

Address (if different from above) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Name \_\_\_\_\_ Work Phone # \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Who is responsible for your bill? Self \_\_\_\_\_ Spouse \_\_\_\_\_ Employer \_\_\_\_\_ Insurance \_\_\_\_\_

Fees are payable at the time Examinations, X-rays, and treatments are received. X-rays and records remain the property of this clinic.

Patient's Signature \_\_\_\_\_ SS# \_\_\_\_\_

Date \_\_\_\_\_