Dempster
Natural Health

Dr. Margaret Dempster, DC, DABCN
799 Roosevelt Road, Building 6, Suite 306
Glen Ellyn, IL 60137
Phone: (630) 588-9300

Today's Date: _____

PATIENT INFORMATION

Patient Name:
(First)_____(Middle Initial)_____(Last)_____
Legal Guardian:_____
Street Address:_____
City:_____ State:_____
Zip:_____
Work Number:_____ Home Number:_____ Cell Number:_____
Sex: Male Female
Marital Status: Single Married Widowed Separated Divorced
Age:_____ Birthday:_____
Employment Status: Full Time Part Time Retired Not Employed
Student Status: Full Time Part Time Non-student
Email Address:_____

EMPLOYMENT INFORMATION

Patient Employed By:_____
Business Address:_____
City:_____ State:_____
Zip:_____
Occupation:_____

SPOUSE INFORMATION

Spouse Name:_____
Birthday:_____
Spouses Employer and Business Address:_____
City:_____ State:_____
Zip:_____
Occupation:_____ Business Phone:_____

CONDITION INFORMATION

Is your condition related to your employment? (current or previous) No Yes Don't Know
Date of Accident:_____
Is your condition related to an automobile accident? No Yes If yes, in which state?
_____
Date of Accident:_____
Have you been involved in an automobile accident in the past three years? No Yes
Date of Accident:_____
Other type of accident? No Yes
Please describe:_____
_____
Date of Accident:

MISC INFORMATION

In case of an emergency, who should we notify?_____
Phone Number:_____ Relationship to Patient:_____
Please list other doctors you have seen in the past 5 years:
1._____
City/State:_____
Reason for seeing:_____
2._____
City/State:_____
Reason for seeing:_____
Whom may we thank for referring you?_____

Add Additional Doctors Below:
3._____
City/State:_____
Reason for seeing:_____
4._____
City/State:_____
Reason for seeing:_____
5._____
City/State:_____
Reason for seeing:_____
7._____
City/State:_____
Reason for seeing:_____
8._____
City/State:_____
Reason for seeing:_____
9._____
City/State:_____
Reason for seeing:_____
10._____
City/State:_____
Reason for seeing:_____