

CA LICENSE: 28999
TAX ID: 20-3241393
CLINIC NPI: 1114107901
DR NPI: 1023297322



SAHARA CLINIC
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Patient Information

Welcome to our office. Please take a moment to tell us about yourself.

Personal Information

Last Name _____ First Name _____ M.I. _____

D.O.B. _____ Social Security # _____ Driver's License # _____

Street Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell / Message # _____

Age _____ Sex _____ Height _____ Weight _____ E-mail _____

If Minor, Parent or Legal Guardian _____

Employer Information

Employer _____ Business Phone # _____

Employer Street Address _____ City _____ State _____ Zip _____

Emergency Contact

Name _____ Phone # _____ Relation _____

Name _____ Phone # _____ Relation _____

Who May We Thank for Referring You? _____

Health History (Please continue any part of this section on the back if you need more space to explain your health issues.)

Primary Reason for coming to Sahara Clinic _____

Is complaint due to an accident? Yes No Date of accident _____

List all allergies _____

List all medications / supplements you are currently taking _____

List any injuries, surgeries, or treatments you have had _____

Medical Physician's Name _____ Contact Phone # _____

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the release of any medical information from my chart to any physician or physicians who may be involved in my medical treatment. **I understand it is my responsibility to update this information as needed. This includes changes in medical conditions, diagnosis, medications and personal & physician contact information.** I agree to be responsible for payment of all services rendered on me or my dependent's behalf.

Signature _____ Date _____

(patient / parent or guardian for minor)