REGISTRATION INFORMATION

Date: _____ (PLEASE PRINT) Home Phone: (____) _____

Patient: _____ Cell Phone: (____) _____
Last Name First Name Middle Initial

Responsible Party (if a minor): _____

Street Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Sex: ☐ M ☐ F Age: _____ Birthdate: _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Patient Employer/School: _____

Employer/School Address: _____

Occupation: _____ Employer/School Phone: (____) _____

Spouse (or responsible party) Employed by: _____

Business Address: _____

Occupation: _____ Business Phone: (____) _____

Purpose of Visit: _____

Who is responsible for this account? _____ Relationship to Patient: _____

Social Security # _____ Spouse's Social Security # _____

Do you have Medical Insurance? ☐ No ☐ Yes ► If yes,

Name of Primary Insurer: _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any): _____

Contract # _____ Group # _____ Subscriber # _____

☐ Medicare ☐ Medicaid Claim ID # _____

If Welfare, your number: _____ County of: _____

I prefer to: ☐ Pay my balance in full at time of service. ☐ Pay my balance in full upon receipt of first statement.

☐ Make payment arrangements prior to services being rendered.

In case of emergency, who should be notified? _____ Phone: (____) _____

Your Drugstore Name: _____ Phone: (____) _____

How did you learn of our practice? _____

INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

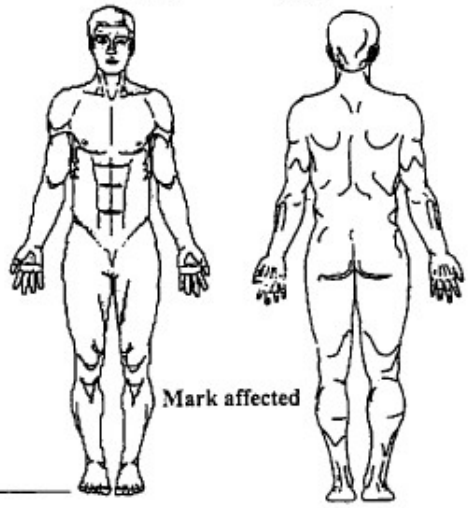
Name _____ Age_____
Please fill in all information which applies to you and please check appropriate box(s)

Occupation: _____ Right handed ☐ Left handed ☐
My problem began on: _____ (closet date/year)
Type of injury/problem
☐ Work related ☐ Injury at home ☐ Slip/fall
☐ Motor Vehicle ☐ Sports injury ☐ Arthritis
☐ Other: _____

Treatment for my problem/injury has included:
☐ Medication ☐ Physical Therapy ☐ Home/Gym exercise
☐ Other Physician ☐ Chiropractor ☐ Injections

Work Status:
☐ Part Time ☐ not working ☐ Light Duty
Have you been seen in the Emergency Room? ☐ Yes ☐ No
Which Hospital_____

Front Back



Mark affected

Diagnostic tests already performed for this problem/injury:
☐ X-Rays ☐ MRI ☐ CT scan ☐ Nerve Test ☐ Bone Scan ☐ other _____

Medication Allergies ☐ None ☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Other _____

Past Medical History: ☐ None

☐ Asthma	☐ Cancer	☐ Bleeding Disorder	☐ Diabetes
☐ Heart disease	☐ Hepatitis	☐ Thyroid Disease	☐ HIV/Aids
☐ Glaucoma	☐ Stroke	☐ Nerve Disease	☐ Lung Disease
☐ Ulcers	☐ High Cholesterol		☐ Tuberculosis
☐ Hypertension	☐ other _____		☐ Migraines
☐ Osteoporosis			

Past Surgical History: ☐ None

☐ Gastrointestinal	☐ Tonsils	☐ Gynecological
☐ Joint replacement	☐ Ear/tubes	☐ Cancer
☐ Hernia	☐ Arthroscopy	☐ Heart
☐ Cataracts'	☐ Hand	☐ Neck/back
☐ Appendectomy	☐ Gall bladder	☐ other _____

Current Medications:

_____

_____

_____

Please check the box if you have any of the following symptoms
☐ bleeding ☐ swelling ☐ Memory loss ☐ ringing in the ears
☐ Incontinence ☐ Blood in stool/urine ☐ Headaches ☐ Chest pain
☐ Palpitations ☐ Cough ☐ Dizziness ☐ Nausea/vomiting
☐ Easy Bruising ☐ Numbness/tingling ☐ Shortness of breathe

Smoker: ☐ Yes ☐ No Do you Drink Alcohol ☐ Yes ☐ No History of substance abuse ☐ Yes ☐ No

Pregnant: ☐ Yes ☐ No Date of last menstrual period _____

If you were in a Motor Vehicle Accident Please answer the following questions
☐ Driver ☐ Passenger front ☐ Passenger Back ☐ Pedestrian
Direction of impact ☐ Front end ☐ Rear end ☐ Passenger side ☐ Driver side
Did your head hit ☐ Dashboard ☐ Windshield?
Loss of conciseness ☐ Yes ☐ No Air bag deployment ☐ Yes ☐ No

Please list any previous accident(s) injuries or any pertinent medical/family history:

_____

Signature _____ Date _____