NEW PATIENT REGISTRATION

1 ABOUT YOU

Today's Date: _____/_____/______ File #: ________________

Name: ____

What You Prefer To Be Called: ____________ Male Female

Birthday: _____/_____/______ Age: ______ SSN: _____________

Home Address: ____

____

City State Zip

Home Phone: ____

Work Phone: ____

Other Phone: ____

Referred By: ____

Employer: ___________________________ How Long? ______

Employer's Address: ___________________________________

____

City State Zip

Occupation: ____

Martial Status: Single Married Divorced Separated Widowed

Spouse's Name: ____

2 INSURANCE

Company Name: _______________________________________

Address: ____

____

City State Zip

Phone Number: ______________________________________

Insured's SSN: _______________________________________

Group Number (Plan, Local or Policy Number):

____

Insured's Name: ______________________________________

Relation: ____

Date of Birth: ____

Insured's Employer: ___________________________________

Please inform the front desk of a second insurance source.

3 REASON FOR VISIT

Have you ever been treated by a Chiropractor before? ❑ Yes ❑ No

If so, please explain: ____

The reason for this visit is a result of *(Please circle)*: ❑ Work ❑ Sports ❑ Auto ❑ Trauma ❑ Chronic

Explain what happened: ____

Please describe the pain and its location: ____

When did the condition begin?____

Is the condition getting worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and Goes

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily Routine

If so, please explain: ____

Have you been treated by a Medical Physician for this condition? ❑ Yes ❑ No

If so, where? ____

Please continue on back

NEW PATIENT REGISTRATION

4 IN EVENT OF EMERGENCY

Who should we contact? ______________________________

Relation: ______________________________

Home Phone: ____________________ Work Phone: ____________________

5 HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve Pills ❑ Pain Killers (Including Aspirin) ❑ Muscle Relaxers ❑ Stimulants

❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) ____________

Have you ever had any of the following diseases / medical conditions? (Check all that apply)

❑ Heart Attack/Stroke	❑ Heart Surgery/Pacemaker	❑ Heart Murmur
❑ Congenital Heart Defect	❑ Mitral Valve Prolapse	❑ Artificial Valves
❑ Alcohol/Drug Abuse	❑ Venereal Disease	❑ Hepatitis
❑ HIV/Aids	❑ Shingles	❑ Cancer
❑ Frequent Neck Pain	❑ Emphysema/Glaucoma	❑ Anemia
❑ High/Low Blood Pressure	❑ Psychiatric Problems	❑ Rheumatic Fever
❑ Severe Frequent Headaches	❑ Kidney Problems	❑ Ulcers/Colitis
❑ Fainting/Seizures/Epilepsy	❑ Sinus Problems	❑ Asthma
❑ Diabetes/Tuberculosis	❑ Difficulty Breathing	❑ Chemotherapy
❑ Lower Back Problems	❑ Artificial Bones/Joints	❑ Arthritis

Please list any other serious medical condition(s) you have or ever had: ____________

____

Please list anything that you may be allergic to: ______________________________

____

List previous surgeries/treatments with dates: ______________________________

____

List any past serious accidents with dates: ______________________________

____

Do you smoke? ❑ Yes ❑ No How much? ____________ How long? ____________

Are you wearing: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports

What is the age of your mattress? ____________ Is it comfortable? ❑ Yes ❑ No

For women: Are you taking Birth Control? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No How long? __________ Nursing? ❑ Yes ❑ No

6 ACCOUNT INFO

Person ultimately responsible for account

Name: ______________________________

Relation: ______________________________

Billing Address: ______________________________

____

City State Zip

SSN: ______________________________

D.L. #: ______________________________

Work Phone: ______________________________

Payment Method: *(Choose One)*

❑ Cash/Check/Credit Card

❑ Insurance

❑ Medicare

❑ Medicaid

CC Number: ______________________________

Exp. Date: _______/_______

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).

- We invite you to discuss with us any questions regarding our services. The best health service are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service an no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.

Signature: ______________________________ Date:_____/_____/______