

CHIROPRACTIC REGISTRATION AND HISTORY

1 PATIENT INFORMATION

Date _____
Patient _____
Address _____
City _____ State _____ Zip _____
Sex: M F Age _____ Birthdate _____
 Single Married Widowed Separated Divorced
Patient SS# _____
Occupation _____
Employer _____
Employer Address _____
Employer Phone _____
Spouse's Name _____
Birthdate _____ SS# _____
Occupation _____
Spouse's Employer _____
Whom may we thank for referring you? _____

2 INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ 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 hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship _____

Date _____

3 PHONE NUMBERS

Home _____ Work _____ Ext _____
Best time and place to reach you _____
IN CASE OF EMERGENCY, CONTACT
Name _____ Relationship _____
Home Phone _____ Work Phone _____

4 ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____
Type of accident Auto Work Home Other
To whom have you made a report of your accident?
 Auto Insurance Employer Worker Comp. Other
Attorney Name (if applicable) _____

5 PATIENT CONDITION

Reason for Visit _____
When did your symptoms appear? _____
Is this condition getting progressively worse? Yes No Unknown
Mark an X on the picture where you continue to have pain, numbness, or tingling.
Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other
How often do you have this pain? _____
Is it constant or does it come and go? _____
Does it interfere with your Work Sleep Daily Routine Recreation
Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down

