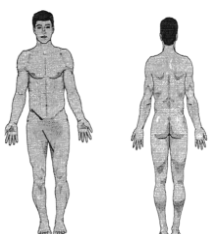


CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION	INSURANCE INFORMATION
Date _____	Who is responsible for this account? _____
Social Security # _____	Relationship to Patient _____
Email _____	Insurance Co. _____
First Name _____	Group # _____
Last Name _____	Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address _____	Subscriber's Name _____
City _____	Birthdate _____ SS# _____
State _____ Zip _____	Relationship to Patient _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____	Insurance Co. _____
Birthdate _____	Group # _____
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor	<p style="text-align: center;">ASSIGNMENT AND RELEASE</p> <p>I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Chiropractic and Health Center 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.</p> <p>The above-named doctor 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.</p>
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years	
Patient Employer/School _____	
Occupation _____	
Employer/School Address _____	
Employer/School Phone (_____) _____	
Spouse's Name _____	
Birthdate _____	
SS# _____	
Whom may we thank for referring you? _____	
PHONE NUMBERS	Signature of Patient, Parent, Guardian or Personal Representative
Cell Phone (_____) _____	Please print name of Patient, Parent, Guardian or Personal Representative
Home Phone (_____) _____	_____
Best time and place to reach you _____	Date _____ Relationship to Patient _____
IN CASE OF EMERGENCY, CONTACT	ACCIDENT INFORMATION
Name _____ Relationship _____	Is this condition due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No
Cell Phone (_____) _____	Date _____
Work Phone (_____) _____	Type of accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other
	To whom have you made a report of your accident?
	<input type="checkbox"/> Auto Insurance <input type="checkbox"/> Employer <input type="checkbox"/> Workers Comp <input type="checkbox"/> Other
	Attorney Name (If applicable) _____
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 <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Lying Down	