

Woodstock Chiropractic New Patient Registration & History Form

1 PATIENT INFORMATION

Date _____

Patient _____

Patient Social Security # _____

Address _____

City _____ State _____ Zip _____

Email _____

Sex: M F Age _____ Birth Date _____

Single Married Widowed Separated Divorced

Occupation _____

Employer _____

Spouse's Name _____

Birthdate _____ Occupation _____

Whom may we thank for referring you? _____

2 PAYMENT INFORMATION

Auto Insurance Claim Commercial Insurance

No Insurance (Self Pay) Medicare

Worker's Compensation

If this is a Commercial Insurance Claim, please fill out the following "Assignment and Release" and provide your health insurance card to the receptionist so she can make a copy of the card. We will file the insurance claim for you.

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage with _____ and assign directly to the Woodstock Chiropractic 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 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

Cell # _____

Home # _____

Work # _____

Please Call My _____ Phone With My Appt. Reminders

IN CASE OF EMERGENCY PLEASE CALL

Name _____

Relation _____

Phone _____ Alt. Phone _____

4 ACCIDENT INFORMATION

Is condition due to an accident? Y N Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Ins Employer Work Comp. Other

Information for Auto Claims Only:

Name of Auto Insurance: _____

Claim # _____ Ph # _____

Adjuster's Name: _____

5 PATIENT CONDITION

Reason for Visit _____

When did you symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark and X on the picture for pain and mark // for numbness and/or tingling.

Please Rate the Severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Pain Rating for Past 24 hrs: _____ Pain Rating for the Past Week: _____

Type of Pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

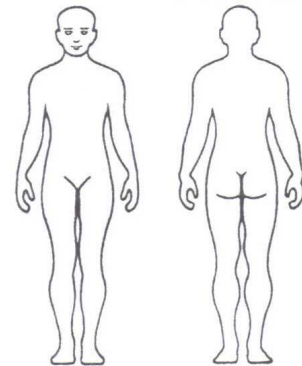
How often do you have this pain? Constant Frequently (50-75% of the day)
 Occasionally (25-50% of the day) Intermittently (under 25% of the day)

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying Down

In general, would you say that your overall health is: Excellent Very Good Good Fair Poor

Patient Signature X _____ Date _____



What treatment have you already received for your condition? Medications Surgery Physical Therpay
 Chiropractic Services None other _____

Name and addres of others doctor(s) who have treated your condition _____

Date of last: Physcial Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT Scan, Bone Scan _____

Please place a mark to indicate if you have had any of the following:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Fractures | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Tumors/Growths |
| <input type="checkbox"/> Breast Lump | <input type="checkbox"/> Hernia | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Prostate Problem | Whooping Cough |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prosthesis | O Other _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care | _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatoid Arthritis | |

EXERCISE	Work Activity	Smoking	Habits
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Alcohol <i>Packs/Day</i> _____	
<input type="checkbox"/> Moderate	<input type="checkbox"/> Standing	<input type="checkbox"/> Coffee/Caffiene <i>Drinks/Week</i> _____	
<input type="checkbox"/> Daily	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High Stress Level <i>Drinks/Week</i> _____	
<input type="checkbox"/> Heavy	<input type="checkbox"/> Heavy Labor		<i>Reason</i> _____

Are you Pregnant? Yes No Due Date _____

Injuries/Surgeries you have had:	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS		VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____

By my signature below , I authorize the Woodstock Chiropractic Center _____ to release any information deemed appropriate to any doctor, insurance company or attorney in the course of my treatment or in order to process any claim for reimbursement of charges. I hereby assign all the right, title and interest relative to insurance benefits to the Woodstock Chiropractic Center. I clearly understand and agree that I am personally responsible for payment of all services rendered to me. Further, in the event that my account is turned over for collection, I understand that I will be responsible for any charges, attorney fees, collection costs and court cost incurred in collecting the balance.

By my signature below, I acknowledge that there are inherent risks involved with spinal manipulation. In 1995, Rand reported the risk of serious complication approximate 1 in 1 million to 1 in 1.5 million. I authorize the doctor to diagnose and treat my condition as deemed appropriate , including the use of spinal manipulation. I understand the above information and guarantee that this form was completed correctly to the best of my knowledge.

SIGNATURE _____ **DATE** _____

IF MINORS, PARENT/GUARDIAN SIGNATURE _____ **DATE** _____