Woodstock Chiropractic New Patient Registration & History Form

1 PATIENT INFORMATION

Date_____

Patient_____

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?_____

Woodstock Chiropractic Center does not currently participate directly with insurance companies. We ask that patients pay for their services at the time of their visit. As a courtesy, we are happy to submit claims to your insurance company on your behalf in the hope that you may be reimbursed according to your policy.

For patients with Medicare coverage, we follow a slightly different process. We charge the reduced Medicare rate at the time of service and submit your claim to Medicare for you so that you may receive any applicable reimbursement directly from them.

If you have any questions about this process or need assistance with your claim submissions, please let us know.

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:_____

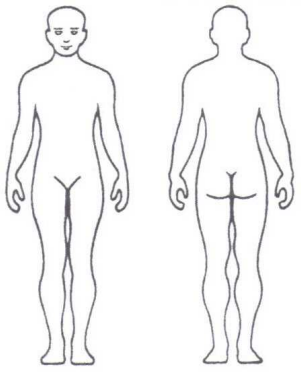
5 PATIENT CONDITION

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:

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

EXERCISE
□ None
□ Moderate
□ Daily
□ Heavy

Work Activity
□ Sitting
□ Standing
□ Light Labor
□ Heavy Labor

Habits
□ Smoking *Packs/Day*_____
□ Alcohol *Drinks/Week*_____
□ Coffee/Caffiene *Drinks/Week*_____
□ High Stress Level *Reason*_____

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**_____