

# REGISTRATION

Date: \_\_\_\_\_

Phone: \_\_\_\_\_

Patient: \_\_\_\_\_  
Last Name First Name Initial

Street Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Sex:  M  F Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Social Security #: \_\_\_\_\_ Email: \_\_\_\_\_

Insured's Name: \_\_\_\_\_  
Last Name First Name Initial

Patient Agreement:

## ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with \_\_\_\_\_  
Name of Insurance Company

and assign directly to **{OFFICE NAME}** all medical 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 my insurance submissions.

\_\_\_\_\_  
Signature of Insured/Guardian

\_\_\_\_\_  
Date

## Present Complaints (Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

**Medical Implants:** \_\_\_\_\_

**Medical alerts:** \_\_\_\_\_

**Surgical Implants:** \_\_\_\_\_

**Pregnancy:** yes \_\_\_ no \_\_\_

**PAIN SCALE:** Rate the severity of your pain by checking a box on the following scale.

<b>No Pain</b>	0	1	2	3	4	5	6	7	8	9	10	<b>Excruciating Pain</b>
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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Medications:** (please list all medications and supplements that you currently take)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Allergies:** (please list all medications that cause allergic reaction)

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Smoking:** \_\_\_ Yes \_\_\_ No If yes, \_\_\_\_\_ Packs per Day for \_\_\_\_\_ years

**Alcohol** \_\_\_ Yes \_\_\_ No If yes, Number of drinks per week \_\_\_\_\_

**Surgical History:** Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____
_____	_____

**Personal Medical History & Review of Systems:**

Please indicate with an "X" any medical problems that you currently have or have had in the past.

**NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

**Lungs / Pulmonary – breathing disorders**

- |                                    |   |   |
|------------------------------------|---|---|
| <input type="checkbox"/> asthma    | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest |
| <input type="checkbox"/> COPD      | <input type="checkbox"/> pneumonia          | <input type="checkbox"/> sleep apnea        |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis       | <input type="checkbox"/> other: _____       |

**Cardiac / Heart and peripheral vascular disease**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> chest pain / angina      | <input type="checkbox"/> high blood pressure          | <input type="checkbox"/> irregular heartbeat, arrhythmia |
| <input type="checkbox"/> heart attack             | <input type="checkbox"/> heart murmur, valve disorder | <input type="checkbox"/> peripheral vascular disease     |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> mitral valve prolapse        | <input type="checkbox"/> deep vein thrombosis            |
| <input type="checkbox"/> other: _____             | <input type="checkbox"/> bleeding problems            |  |

**Neurologic Disorders**

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> stroke or TIA         | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> cerebral palsy |
| <input type="checkbox"/> peripheral neuropathy | <input type="checkbox"/> MS          | <input type="checkbox"/> polio          |
| <input type="checkbox"/> other: _____          |                                      |   |

**Bone & Joint Disorders**

- |   |                                |   |
|---|--------------------------------|---|
| <input type="checkbox"/> osteoarthritis       | <input type="checkbox"/> gout  | <input type="checkbox"/> osteomyelitis          |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> lupus | <input type="checkbox"/> ankylosing spondylitis |
| <input type="checkbox"/> other: _____         |                                |   |

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Gastrointestinal Disorders**

- peptic ulcer or stomach ulcer
- acid reflux, GERD
- GI bleed
- other: \_\_\_\_\_
- diverticulitis
- irritable bowel
- inflammatory bowel disease
- hepatitis - Type \_\_\_\_\_
- liver disease

**Genitourinary Disorders**

- urinary tract infection
- bladder problems
- kidney problems
- kidney stones
- dialysis, kidney failure
- other: \_\_\_\_\_

**Metabolic & Other Disorders**

- Diabetes x \_\_\_\_\_ years
- thyroid problems
- sickle cell disease
- high cholesterol or lipids
- skin disorder \_\_\_\_\_
- psoriasis
- any skin ulcer
- tooth abscess, gingivitis
- depression
- anxiety
- alcohol or drug dependency
- other: \_\_\_\_\_

Cancer : any type -- please specify

\_\_\_\_\_

Other medical problems NOT included above (explain)

\_\_\_\_\_  
\_\_\_\_\_

**Family History:**

Please indicate with an "X" any significant family medical history or problems.

- asthma
- COPD or Emphysema
- heart attack, myocardial infarction
- irregular heartbeat, arrhythmia
- MS or Parkinson's
- osteoarthritis
- rheumatoid arthritis
- acid reflux, GERD
- liver disease
- kidney problems
- diabetes
- thyroid problems
- Malignant hyperthermia
- tuberculosis
- other lung : \_\_\_\_\_
- congestive heart failure
- bleeding problems
- Peripheral neuropathy
- other neuro : \_\_\_\_\_
- Lupus
- Other bone & joint: \_\_\_\_\_
- inflammatory bowel disease
- other GI : \_\_\_\_\_
- sleep apnea
- gout
- hepatitis - Type \_\_\_\_\_
- dialysis, kidney failure
- high cholesterol or lipids
- any skin ulcer

Cancer : any type -- please specify

\_\_\_\_\_

Other medical problems NOT included above (explain)

\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

**PATIENT INSURANCE INFORMATION:**

Please check any and all insurance coverage you or your spouse has applicable in this case.

- |                                     |  |  |
|-------------------------------------|--|--|
| <input type="checkbox"/> Medicare   | <input type="checkbox"/> Blue Shield           | <input type="checkbox"/> Auto Accident |
| <input type="checkbox"/> Medicaid   | <input type="checkbox"/> Major Medical         | <input type="checkbox"/> Union Plan    |
| <input type="checkbox"/> Blue Cross | <input type="checkbox"/> Worker's Compensation | <input type="checkbox"/> Other         |

Insurance Identification Number: \_\_\_\_\_

Medicare/Medicaid Identification Number: \_\_\_\_\_

**Major Medical or Auto Insurance:**

Date of Accident: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Adjuster: \_\_\_\_\_

Address/Phone: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Primary Care Physician:**

Name & Address:

\_\_\_\_\_

Phone #: \_\_\_\_\_

**LEGAL INFORMATION:**

Attorney Name & Address:

\_\_\_\_\_

\_\_\_\_\_

Attorney Phone #: \_\_\_\_\_

\*Person to contact in an emergency (Name and Phone #):

\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_