CHIROPRACTIC REGISTRATION & HISTORY

Pt Code ________ Date __________

PATIENT INFORMATION

Patient Name ___________________________________
Nick Name / Maiden Name _______________________
Address _______________________________________
____
____
Gender: ☐ M ☐ F Age ______________
Birth Date ______________ SSN _______________
☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced
Home Phone ____________________________________
Mobile Phone ___________________________________
Work Phone ____________________________________
Email ____
May we communicate with you via email?
☐ Yes ☐ No
Best time and place to reach you _________________
____
Occupation _____________________________________
Employer _______________________________________
Employer Address ________________________________
____
Employer Phone __________________________________
Spouse's Name ___________________________________
Birth date _________ SSN ______________________
Occupation _____________________________________
Spouse's Employer ________________________________
Whom may we thank for referring you? _____________
____

EMERGENCY CONTACT

Name ____
Relationship ____________________________________
Home Phone _____________________________________
Work Phone _____________________________________
Mobile Phone ____________________________________

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No
Date of Accident _________________________________
Type of Accident ☐Auto ☐Work ☐Home ☐Other
To whom have you made a report of your accident?
☐ Auto Ins. ☐ Employer ☐ Work. Comp. ☐ Other
Attorney's Name (if applicable) ___________________

INSURANCE

Who is responsible for this account? _______________
Relationship to Patient __________________________
Insurance Co. ___________________________________
Policy #___________________ Group # ____________
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name _______________________________
Birth date ___________ SSN _____________________
Relationship to Patient __________________________
Insurance Co. ___________________________________
Policy #___________________ Group # ____________

ASSIGNMENT & RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with, ______________________, and assign directly to Dr. Adkins all insurance benefits, if any, otherwise payable to me for services rendered. All professional services rendered are charged to the patient. I understand that I am financially responsible for all charges whether or not paid by insurance. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. I further understand that should I fail to pay my account balance, I will be responsible for all collection charges incurred, including thirty-five percent (35%) collection agency fees if placed with a collection agency, plus reasonable attorney fees and court costs if legal action is instituted to enforce collection of any balance owed. 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's Signature

________________________ ________________
Relationship to Patient Date

PATIENT CONDITION

Reason for visit _________________________________
____
When did your symptoms first appear? ______________
Is this condition getting progressively worse?
☐ Yes ☐ No ☐ Unknown
Rate the severity of 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
Check the activities or movements that are painful to perform:
☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Lying Down

-over-