PATIENT REGISTRATION FORM (GENERAL)

DATE____________________

NAME____ PHONE # __________________
FIRST MIDDLE INITIAL LAST

ADDRESS____CELL # __________________

CITY ________________________ STATE __________ ZIP CODE __________________ WORK # ___________________

SSN #____________________ DL #__________________ DATE OF BIRTH ________________ AGE_____ MALE/FEMALE

EMPLOYER ____ OCCUPATION ________________________

ADDRESS ____ PHONE # ____________________________

EMERGENCY CONTACT __________________________________ PHONE # ____________________________

PRIMARY PHYSICIAN__________________________________ PHONE # ____________________________

WHERE YOU REFERRED TO OUR OFFICE BY ANY HEALTHCARE PROVIDER? YES NO

INSURANCE INFORMATION / METHOD OF PAYMENT

☐ CASH / CHECK ☐ GENERAL HEALTH INSURANCE ☐ OREGON HEALTH PLAN ☐ MEDICARE

HEALTH INSURANCE ____

ID #____ GROUP #____

SUBSCRIBER NAME____ ☐ SELF ☐ OTHER

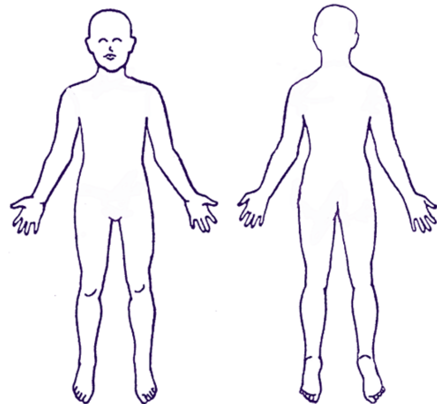
DO YOU HAVE SECONDARY COVERAGE? YES NO IF YES, ____

PLEASE INDICATE REGION(S) OF COMPLAINT

☐ HEADACHE
☐ NECK
☐ UPPER / MID BACK
☐ LOW BACK
☐ SHOULDER / ELBOW / WRIST / HAND / FINGER
☐ HIP / THIGH / KNEE / ANKLE / FOOT / TOE
☐ RIB / ABDOMEN / CHEST
☐ OTHER ____

____

PLEASE MARK REGION(S) OF COMPLAINT:



PATIENT CONDITION

WHEN DID YOUR SYMPTOMS APPEAR? ____

WAS THERE A SPECIFIC INJURY ☐ YES ☐ NO IF YES, EXPLAIN ____

IS THIS CONDITION GETTING PROGRESSIVELY WORSE? ☐ YES ☐ NO ☐ UNKNOWN

OVERALL, RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1 (LEAST PAIN) TO 10 (SEVERE PAIN) _______

IS IT CONSTANT OR DOES IT COME AND GO? ____

HOW OFTEN DO YOU HAVE THIS PAIN? ____

DOES IT INTERFERE WITH YOUR ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ RECREATION

ACTIVITIES THAT ARE PAINFUL TO PERFORM ☐ SITTING ☐ STANDING ☐ WALKING ☐ BENDING ☐ LYING

MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAM ___________________

☐ PRIOR IMAGING (X-RAYS, MRI, CT SCAN ETC.)
DATE ______________________

☐ PREVIOUS CHIROPRACTIC TREAMENT

WHERE _____________________________________

☐ ARTHRITIC CONDITION
☐ CANCER
☐ DIABETES
☐ HEART PROBLEMS
☐ HIGH BLOOD PRESSURE
☐ VASCULAR CONDITION
☐ LUNG PROBLEMS
☐ USUAL CHILDHOOD DISEASES
☐ UNUSUAL CHILDHOD DISEASES
☐ CURRENTLY PREGNANT
DUE DATE______________________
☐ RECREATIONAL DRUGS
☐ TOBACCO USE HOW MUCH __________________
☐ ALCOHOL USE HOW MUCH __________________
☐ ALLERGIES
☐ BIRTH CONTROL MEDICATIONS
☐ EXERCISE
☐MODERATE
☐DAILY
☐HEAVY

MEDICATIONS/ALLERGIES/INJURIES

LIST MEDICATIONS
____
____
____

ALLERGIC TO MEDICATION
____
____
____

ALLERGIES
____
____
____

SURGERIES/HOSPITALIZATIONS/INJURIES
____
____
____

PRIOR AUTO ACCIDENTS OR WORK INJURIES
____
____
____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION / FINANCIAL AGREEMENT

I UNDERSTAND AND AGREE THAT REGARDLESS OF INSURANCE COVERAGE, I AM LIABLE FOR ANY CHARGES INCURRED AS A RESULT OF SERVICES RENDERED TO ME AT DC CHIROPRACTIC CENTER. IF THIS ACCOUNT IS ASSIGNED TO AN ATTORNEY FOR COLLECTION AND/OR SUIT, THE PREVAILING PARTY SHALL BE ENTITLED TO REASONABLE ATTORNEY'S FEES AND COST OF COLLECTIONS. I AUTHORIZE RELEASE OF PATIENT MEDICAL RECORDS TO THIRD PARTIES REQUIRING THESE RECORDS FOR DETERMINATION OF FINANCIAL LIABILITY.

SIGNATURE____ **DATE**__________________