PATIENT REGISTRATION FORM (AUTO AND PERSONAL INJURY)

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 # _____

PRIVATE PHYSICAN _____ PHONE # _____

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

INSURANCE INFORMATION / METHOD OF PAYMENT

☐ AUTO INSURANCE ☐ SLIP AND FALL ☐ PERSONAL INJURY ☐ GENERAL HEALTH INSURANCE

INSURANCE COMPANY_____ PHONE # _____

CLAIMS ADJ._____ PHONE # _____ EXT_____

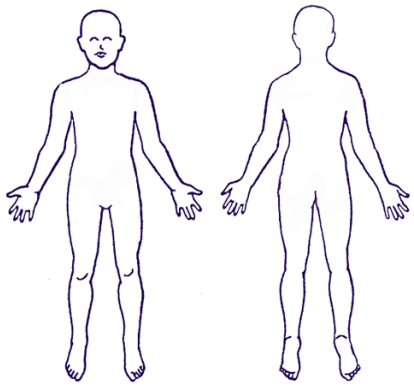
POLICY #_____ CLAIM #_____ ARE YOU THE POLICYHOLDER? Y N

PLEASE INDICATE REGION(S) OF COMPLAINT

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

_____

PLEASE MARK REGIONS(S) OF COMPLAINT:



WHEN DID YOUR SYMPTOMS FIRST 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

CHECK SYMPTOMS APPARENT <u>SINCE</u> THE ACCIDENT:

☐ DIZZINESS	☐ CHEST PAIN	☐ JAW PROBLEMS	☐ NAUSEA
☐ MEMORY LOSS	☐ IRRITABILITY	☐ ARMS / SHOULDER PAIN	☐ MID BACK PAIN
☐ HEADACHE	☐ FATIGUE	☐ NUMB HANDS / FINGERS	☐ LOWER BACK PAIN
☐ BLURRED VISION	☐ TENSION	☐ DIFFICULTY SLEEPING	☐ BACK STIFFNESS
☐ BUZZING IN EARS	☐ NECK PAIN	☐ SHORTNESS OF BREATH	☐ LEG PAIN
☐ RINGING IN EARS	☐ STIFF NECK	☐ UPSET STOMACH	☐ NUMB FEET / TOES

PERSONAL INJURY INFORMATION

DATE OF INJURY_____ TIME OF INJURY_____ LOCATION OF ACCIDENT_____

☐ AUTO VS AUTO ☐ AUTO VS TRUCK ☐ MOTORCYCLE ☐ AUTO VS BUS ☐ AUTO VS PEDESTRIAN

☐ SLIP AND FALL ☐ OTHER_____

BRIEFLY DESCRIBE ACCIDENT_____

_____

☐ DRIVER ☐ PASSENGER ☐ FRONT SEAT ☐ BACK SEAT ☐ SEATBELT ☐SHOULDER HARNESS

BODY PARTS STRUCK? ☐ YES ☐ NO IF YES, PLEASE LIST_____

☐ EMERGENCY TREATMENT? IF YES, WHERE? _____

WERE X-RAYS TAKEN? ☐ YES ☐ NO WHERE?_____

LOSS OF CONSCIOUSNESS? ☐ YES ☐ NO

☐ WORK RELATED? IF YES, ANY LOSS OF WORK? ☐ YES ☐ NO

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** _____