PATIENT REGISTRATION FORM (WORKERS' COMPENSATION)

DATE_____

NAME_____ PHONE # _____
FIRST MIDDLE INITIAL LAST

ADDRESS_____CELL # _____

CITY _____ STATE _____ ZIP CODE _____ WORK # _____

SSN #_____ DL #_____ DATE OF BIRTH_____ AGE_____ MALE/FEMALE

EMERGENCY CONTACT _____ PHONE # _____

PRIVATE PHYSICIAN _____ PHONE # _____

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

INSURANCE INFORMATION / METHOD OF PAYMENT

☐ WORKERS COMPENSATION INSURANCE ☐ GENERAL HEALTH INSURANCE

INSURANCE COMPANY_____ PHONE # _____

CLAIMS ADJ._____ PHONE #_____ EXT _____

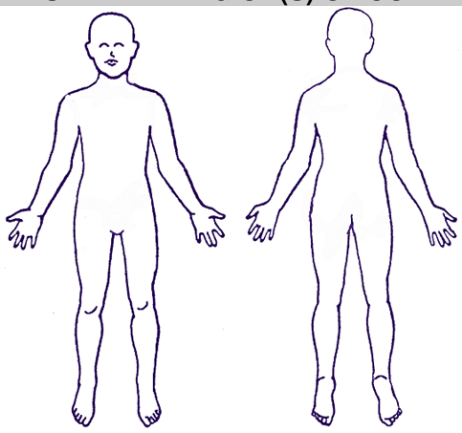
POLICY # _____ GROUP # _____ CLAIM # _____

PLEASE INDICATE REGION OF COMPLAINT

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

_____

PLEASE MARK REGION(S) OF COMPLAINT



PATIENT CONDITION

WHEN DID YOUR SYMPTOMS APPEAR? _____

WAS THERE A SPECIFIC INJURY ☐ YES ☐ NO

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

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

WORKERS' COMPENSATION INJURY / EMPLOYER INFORMATION

COMPANY NAME_____

ADDRESS_____

CITY-STATE-ZIP_____

DATE OF INJURY_____ TIME OF INJURY_____ DATE LAST WORKED _____

BRIEFLY DESCRIBE INJURY _____

_____

☐ EMERGENCY TREATMENT? IF YES, WHERE? _____

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

LOSS OF CONSCIOUSNESS? ☐ YES ☐ NO

MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAM _____

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

☐ PREVIOUS CHIROPRACTIC TREATMENT
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**_____