

# PATIENT REGISTRATION

## PERSONAL INFORMATION:

First Name: \_\_\_\_\_ Middle Init. \_\_\_\_\_ Last Name \_\_\_\_\_  
Street Address: \_\_\_\_\_ PO Box \_\_\_\_\_  
City & State: \_\_\_\_\_ ZipCode \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Referral Source: \_\_\_\_\_ Social Security # \_\_\_\_\_  
Reason For Visit: \_\_\_\_\_  
How Long Have You Had This Problem? \_\_\_\_\_  
Have You Experienced Chiropractic Before? \_\_\_\_\_  
Is This Related To An Auto Accident? \_\_\_\_\_  
Date Of Accident: \_\_\_\_\_  
Do You Have A Copy Of The Police Report? \_\_\_\_\_

## EMPLOYMENT INFORMATION:

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Office Phone: \_\_\_\_\_

## INSURANCE INFORMATION:

Primary Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Ins. ID# \_\_\_\_\_ Group # \_\_\_\_\_ Policy / Plan # \_\_\_\_\_  
Claim # \_\_\_\_\_ Adjuster: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
Insured's DOB: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_  
Address: \_\_\_\_\_  
Ins. ID# \_\_\_\_\_ Group # \_\_\_\_\_ Policy / Plan # \_\_\_\_\_  
Claim # \_\_\_\_\_ Adjuster: \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_  
Insured's DOB: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_

## ATTORNEY INFORMATION:

Attorney's Name: \_\_\_\_\_  
Attorney's Address: \_\_\_\_\_  
Attorney's Phone #: \_\_\_\_\_

## PATIENT ASSIGNMENT RELEASE

I, the undersigned, have insurance coverage with \_\_\_\_\_ insurance company and assign directly to Southwest Family Chiropractic, LLC all medical benefits, if any, otherwise payable to me for services rendered. *I understand that I am financially responsible for all charges incurred, whether or not they are reimbursed \ paid by any third party insurance.* I hereby authorize the doctor to release all the information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured \_\_\_\_\_ Date \_\_\_\_\_



(Cont. Medical History)

Chiropractic Physician: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Other Doctors Seen: Specialtys: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

**ADVANCED TESTING:**

MRI: Date \_\_\_\_\_ Reason / Results: \_\_\_\_\_

CT Scan: Date \_\_\_\_\_ Reason / Results: \_\_\_\_\_

Blood Tests: Date \_\_\_\_\_ Reason / Results: \_\_\_\_\_

Bone Scan: Date \_\_\_\_\_ Reason / Results: \_\_\_\_\_

X-Rays: Date \_\_\_\_\_ Reason / Results: \_\_\_\_\_

NCV: Date \_\_\_\_\_ Reason / Results: \_\_\_\_\_

HOSPITAL VISITS: \_\_\_\_\_ ER / \_\_\_\_\_ Admitted. Dates From \_\_\_\_\_ To \_\_\_\_\_

Reasons/Cause: \_\_\_\_\_

**Traumas in past 20 years:**

Motor Vehicle: Dates: \_\_\_\_\_ Describe: \_\_\_\_\_

Work Related: Dates: \_\_\_\_\_ Describe: \_\_\_\_\_

Sports Related: Dates: \_\_\_\_\_ Describe: \_\_\_\_\_

Slip/Fall: Dates: \_\_\_\_\_ Describe: \_\_\_\_\_

Fractures: Dates: \_\_\_\_\_ Describe: \_\_\_\_\_

**Current Medications:**

Name: \_\_\_\_\_ Reason: \_\_\_\_\_

Name: \_\_\_\_\_ Reason: \_\_\_\_\_

Name: \_\_\_\_\_ Reason: \_\_\_\_\_

**VITAMINS:**

Name: \_\_\_\_\_ Reason: \_\_\_\_\_

Name: \_\_\_\_\_ Reason: \_\_\_\_\_

Name: \_\_\_\_\_ Reason: \_\_\_\_\_

**MAJOR ILLNESSES:** Please place an "S" for Self or "F" for Family.

CONDITIONS: \_\_\_\_\_ Cancer \_\_\_\_\_ HIV \_\_\_\_\_ Diabetes \_\_\_\_\_ Kidney Ds. \_\_\_\_\_ Heart Ds. \_\_\_\_\_ Pacemaker

\_\_\_\_\_ Thyroid \_\_\_\_\_ Arthritis \_\_\_\_\_ Liver Ds. \_\_\_\_\_ MS \_\_\_\_\_ Prostate \_\_\_\_\_ Stroke \_\_\_\_\_ Tumors

\_\_\_\_\_ Ulcers \_\_\_\_\_ Depression \_\_\_\_\_ Diff. Sleeping \_\_\_\_\_ Dizziness \_\_\_\_\_ Fainting \_\_\_\_\_ Loss of Weight

\_\_\_\_\_ Weight Gain \_\_\_\_\_ Fatigue \_\_\_\_\_ Forgetfulness \_\_\_\_\_ Shaking/Hand Tremors

GASTRO: \_\_\_\_\_ Bloating \_\_\_\_\_ Constipation \_\_\_\_\_ Diarrhea \_\_\_\_\_ Excessive Hunger \_\_\_\_\_ Gas

\_\_\_\_\_ Excessive Thirst \_\_\_\_\_ Indigestion \_\_\_\_\_ Nausea \_\_\_\_\_ Stomach Pain \_\_\_\_\_ Vomiting \_\_\_\_\_ Bloody Stool

CARDIOVASCULAR: \_\_\_\_\_ Chest Pain \_\_\_\_\_ High BP \_\_\_\_\_ Low BP \_\_\_\_\_ Poor Circulation

\_\_\_\_\_ Irregular heart beat \_\_\_\_\_ Swelling of ankles

SKIN: \_\_\_\_\_ Bruise easily \_\_\_\_\_ Change in moles \_\_\_\_\_ Rashes \_\_\_\_\_ Scars \_\_\_\_\_ Itching \_\_\_\_\_ Hives

\_\_\_\_\_ Sores that won't heal

EYES/EARS/NOSE/THROAT: \_\_\_\_\_ Blurred Vision \_\_\_\_\_ Double Vision \_\_\_\_\_ Earache \_\_\_\_\_ Nosebleeds

\_\_\_\_\_ Loss of Hearing \_\_\_\_\_ Ringing in Ears \_\_\_\_\_ Sinus problems

\_\_\_\_\_ Allergies: Describe \_\_\_\_\_

\_\_\_\_\_ Other conditions the Dr. should be aware of: \_\_\_\_\_

Pt. Signature: \_\_\_\_\_ Date: \_\_\_\_\_