

PATIENT REGISTRATION

PATIENT INFORMATION

Date _____
 SS#: _____
 Patient Name _____
 E-mail _____
 Address _____
 City _____
 State _____ Zip _____
 Home Phone # (____) _____ - _____
 Cell Phone # (____) _____ - _____
 Work Phone # (____) _____ - _____
 Sex: Male Female Age _____
 Birthdate: _____
 Employer _____
 Occupation _____
 Spouse's Name _____
 Spouse's Employer _____
 Who referred you? _____
 Name of family physician _____
 May we contact them regarding your health? Yes No

INSURANCE INFORMATION

Who is responsible for this account? _____
 Relationship to patient _____
 Insurance Co.: _____
 Group #: _____ ID# _____
 Subscriber Birthdate: ____/____/____ Subscriber SS#: ____ - ____ - ____
 Are you covered by additional insurance? Yes No
 Secondary Insurance Co.: _____
 Group # _____ ID# _____

ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s) have insurance coverage with _____ and assign directly to Norton Chiropractic Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Signature of Patient, Parent, Guardian or Personal Rep. _____ Date _____

ACCIDENT INFORMATION

Injury due to an accident? Yes No
 If yes, Date of accident _____
 Type of accident Auto Work Home Other
 Have you made a report of your accident? Yes No
 To Whom? Auto Insurance Employer Workers' Comp
 Other _____
 Attorney Name (if applicable) _____

EMERGENCY CONTACT

Emergency Contact Information

Name _____ Relationship _____ Home _____ Work _____

PATIENT CONDITION (HPI)

Reason for visit _____
 When did your symptoms start? _____
 How did your problem start? _____
 Rate your pain level **today**: (please circle one)
 0 1 2 3 4 5 6 7 8 9 10
No Pain **Severe Pain**
 Is your pain? Constant Frequent Occasional Intermittent
 (100% of day) (75% of day) (50% of day) (25% of day)
 Describe the pain: Sharp Dull ache Shooting Burning
 Throbbing Stabbing Numbness Tingling
 Is your condition? Getting Better Staying the same Getting Worse
 Does it interfere with? Work Sleep Recreation Daily Activity Nothing
 What makes you worse? Sitting Standing Walking Bending Lying down
 What makes you better? Nothing Rest Activity Heat Cold Medication
 What tests have you had? X-rays MRI EMG Ultrasound Lab work
 What treatment have you had? Drugs Nerve blocks PT Surgery
 Has the treatment helped? Yes No Have you ever had this problem before? Yes No

(Please mark your areas of pain)



