REGISTRATION

Date: _____ Phone: _____

Patient: _____ _____ _____
Last Name First Name Initial

Street Address: _____

City/State/Zip Code: _____

Sex: ☐ M ☐ F Age: ____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #: _____ Email: _____

Insured's Name: _____ _____ _____
Last Name First Name Initial

Patient Agreement:
ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to **{OFFICE NAME}** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

Present Complaints (Please circle the appropriate ones)

Headache
Mental dullness
Loss of memory
Dizzy
Ears ringing/buzzing
Upper back pain
Lower back pain
Midback pain
Pins and needles in hands right/left

Feet/Hands Cold
Depression
Rib pain
Nervousness
Eye strain/pain
Shortness of breath
Fear
Confusion
Pins and needles in arms right/left

Unbalanced
Fainting
Blurred vision
Irritability
Double vision
Loss of smell
Chest pain
Neck pain
Pins and needles in legs right/left

Medical Implants: _____ **Medical alerts:** _____
Surgical Implants: _____ **Pregnancy:** **yes** ____ **no** ____

PAIN SCALE: Rate the severity of your pain by checking a box on the following scale.

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Excruciating Pain**

Patient Name: _____ Date: _____

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____
_____ _____
_____ _____
_____ _____

Personal Medical History & Review of Systems:
Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma □ pulmonary embolism □ respiratory arrest
□ COPD □ pneumonia □ sleep apnea
□ emphysema □ tuberculosis □ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina □ high blood pressure □ irregular heartbeat, arrhythmia
□ heart attack □ heart murmur, valve disorder □ peripheral vascular disease
□ congestive heart failure □ mitral valve prolapse □ deep vein thrombosis
□ other: _____ □ bleeding problems

Neurologic Disorders

□ stroke or TIA □ Parkinson's □ cerebral palsy
□ peripheral neuropathy □ MS □ polio
□ other: _____

Bone & Joint Disorders

□ osteoarthritis □ gout □ osteomyelitis
□ rheumatoid arthritis □ lupus □ ankylosing spondylitis
□ other: _____

Patient Name: _____ Date: _____

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer
□ acid reflux, GERD
□ GI bleed
□ other: _____
□ diverticulitis
□ irritable bowel
□ inflammatory bowel disease
□ hepatitis - Type _____
□ liver disease

Genitourinary Disorders

□ urinary tract infection
□ bladder problems
□ kidney problems
□ kidney stones
□ dialysis, kidney failure
□ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years
□ thyroid problems
□ sickle cell disease
□ high cholesterol or lipids
□ skin disorder _____
□ psoriasis
□ any skin ulcer
□ tooth abscess, gingivitis
□ depression
□ anxiety
□ alcohol or drug dependency
□ other: _____

Cancer : any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma
□ tuberculosis
□ sleep apnea
□ COPD or Emphysema
□ other lung :_____
□ heart attack, myocardial infarction
□ congestive heart failure
□ irregular heartbeat, arrhythmia
□ bleeding problems
□ Peripheral neuropathy
□ MS or Parkinson's
□ other neuro :_____
□ osteoarthritis
□ Lupus
□ gout
□ rheumatoid arthritis
□ Other bone & joint: _____
□ acid reflux, GERD
□ inflammatory bowel disease
□ hepatitis - Type _____
□ liver disease
□ other GI :_____
□ kidney problems
□ dialysis, kidney failure
□ diabetes
□ psoriasis
□ high cholesterol or lipids
□ thyroid problems
□ sickle cell disease
□ any skin ulcer
□ Malignant hyperthermia

Cancer : any type -- please specify

_____

Other medical problems NOT included above (explain)

_____

_____

Patient Name: _____ Date: _____

PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

☐ Medicare	☐ Blue Shield	☐ Auto Accident
☐ Medicaid	☐ Major Medical	☐ Union Plan
☐ Blue Cross	☐ Worker's Compensation	☐ Other

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance:

Date of Accident: _____

Insurance Company Name: _____

Adjuster: _____

Address/Phone: _____

Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:

Name & Address:

_____

_____

Phone #: _____

LEGAL INFORMATION:

Attorney Name & Address:

_____

_____

Attorney Phone #: _____

*Person to contact in an emergency (Name and Phone #):

_____

Patient Name: _____ Date: _____

MOTOR VEHICLE COLLISION QUESTIONNAIRE

Please answer all questions completely:

1: Your name and address:

_____

_____

2: Phone Number: _____

3: Please describe the collision in your own words:

_____

_____

4: Where did the collision occur? City/Town: _____ State: _____

5: Date of collision: _____ Time: _____ AM PM

6: Were you the: driver passenger pedestrian

7: If passenger, were you in the front seat right rear seat left rear seat

8: What type of vehicle were you in? _____

9: What type was the other vehicle? _____

10: Did your vehicle strike the other vehicle? yes no

11: Was your car struck by the other vehicle? yes no

12: What direction was your vehicle going? _____

13: What direction was the other vehicle going? _____

14: Was the impact from: the front the rear the left side the right side

15: What was the approximate speed at the time of the impact?

16: Your vehicle _____ mph Other vehicle _____ mph

17: What was the weather at the time of the collision? dry wet icy

18: Was your vehicle in: park neutral in gear moving stopped

19: Were your brakes being applied? yes no

20: Was your vehicle shoved: forward backward sideways

21: Were you shoved: forward whipped backward

22: Did your seat have a head restraint (headrest?) yes no

Patient Name: _____ Date: _____

23: If yes, what was the position low mid-position high

24: Did your head ride over the headrest? yes no

25: Did your hat/glasses end up in the back seat or rear window? yes no

26: Did any other part of your body hit the interior of the vehicle? yes no

27: If yes, please specify: seatbelt restraints steering wheel dashboard windshield side door side window other _____

28: Which part of your body? chest head chin face R L knee R L shoulder R L hand other _____

29: Were you holding on to the steering wheel? yes no

30: Did you brace your arms against the dash? yes no

31: Did you brace your legs against the floorboard? yes no

32: Was your ankle turned? yes no

33: Did the vehicle go into a spin or roll as a result of the impact? yes no

If yes, explain: _____

34: How much damage was there to the outside of the vehicle? none some a lot

35: How much damage was there to the inside of the vehicle? none some a lot

36: At the point of impact, where did you experience pain? Be specific:

_____

37: Immediately after the accident were you: conscious dazed unconscious

38: If you lost consciousness, how long? _____

39: Were you wearing a seat belt? yes no

40: Did the belt have a shoulder harness? yes no

If yes, did it contribute to the pain you are experiencing? yes no

41: At the time of impact were you: looking straight ahead looking to the right looking to the left looking down looking up

42: Did the seat break as a result of the impact? yes no

43: Were you braced for the impact? yes no

44: Were you surprised by the impact? yes no

45: Did you go to the hospital? yes no

46: If yes, when? right after the accident next day other _____

47: If yes, how did you get there? ambulance other: _____

Patient Name: _____ Date: _____

48: If by ambulance, did the ambulance attendants place you in a: neck brace

back brace other _____

49: Any medication or medical supplies given? _____

50: Did you have x-rays taken at the hospital? yes no

51: If you went to the hospital, please answer the following:

Name of hospital _____

Treatment Received _____

52: Have you had any similar problems before? yes no

If yes, explain: _____

53: Are you diabetic? yes no

54: Do you have high blood pressure? yes no

55: Do you have low blood pressure? yes no

56: Do you have arthritis or degenerative joint disease? yes no

57: What type of work do you do? _____

58: What are your job requirements? _____

59: Have you lost any days of work from this injury? yes no

If yes, give dates: _____

Patient Name: _____ Date: _____

_____ Doctor Reviewed with Patient

Doctor Signature: _____ Date: _____