

## Welcome

	PATIENT INFORMATION	INSURANCE				
	Date	Who is responsible for this account?				
3	SS/HIC/Patient ID #	Relationship to Patient				
450		Insurance Co.				
		Group #				
Patient Name		Is patient covered by additional insurance? ☐ Yes ☐ No				
Last Na	me First Name M. I.	Subscriber's Name				
Address		Birthdate SS#				
City	StateZip	Relationship to Patient				
E-mail		Insurance Co.				
Sex M F Age	Birthgate	Group #				
	Ndowed Single  Minor	ASSIGNMENT AND RELEASE I certify that I, and/or my dependent(s) have insurance coverage with				
☐ Separated ☐ Di	vorced Partnered for years	and assign directly to				
Occupation	X	Name of Insurance Company(les)				
Patient Employer/School		Drall insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am				
Employer/School Addres	ss	financially responsible for all charges whether or no paid by insurance. I authorize the use of my signature on all insurance submissions.				
/		The above-named doctor may use my health care information and may disclose				
Employer/School Phone		such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance				
Spouse's Name		benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.				
Birthdate						
SS#		Signature of Patient, Parent, Guardian or Personal Representative				
Spouse's Employer		Please print name of Patient, Parent, Guardian or Personal Representative				
	referring you?					
2		Date Relationship to Patient				
	IONE NUMBERS	ACCIDENT INFORMATION				
Home Phone ()_		Is condition due to an accident? ☐ Yes ☐ No				
Cell Phone ()	and the same	Date				
Best time and place to re IN CASE OF EMERGEN		Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other				
		To whom have you made a report of your accident?  ☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other				
		Attorney Name (if applicable)				
Home Phone () _		Attento (il applicable)				
Work Phone ()	DATION	CONDITION				
		CONDITION				
OVERPOR ON THE ON HOUSE BARRIES		0 (				
	appear? rogressively worse?	The state of the s				
	where you continue to have pain, numbness, or					

Type of pain:

How often do you have this pain?\_

Is it constant or does it come and go?\_

☐ Shooting

☐ Other

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling

Activities or movements that are painful to perform  $\square$  Sitting  $\square$  Standing  $\square$  Walking  $\square$  Bending  $\square$  Lying Down

Albat traatma	at have you s	droady re	eceived for your cond	Andrew Control		ions Surgery	□ Phy	sical The	erany		Series (A	
what treatmen						ions 🗌 ourgery						
Vision and aid	☐ Chiropra											
Date of Last: Physical Exam												
Spinal Exam  Dental X-Ray									Office rest			
								-				
		Managerage	licate if you have ha		Parameter Pro-		□ Voc	□ No	Psychiatric Care	□Yes	□No	
AIDS/HIV	☐ Yes	□ No	Chicken Pox		□ No	Liver Disease Measles	☐ Yes	□ No	Rheumatoid	☐ Yes	□ No	
Alcoholism Allergy Shots	☐ Yes	□ No	Diabetes Emphysema	☐ Yes	21.111	Migraine	Yes	□ No	Arthritis			
Anemia	☐ Yes	□No	Epilepsy	☐ Yes	□No	Headaches			Rheumatic Fever	☐ Yes	□ No	
Anorexia	☐ Yes	□No	Fractures	☐ Yes	□No	Miscarriage	☐ Yes	☐ No	Scarlet Fever	Yes	☐ No	
Appendicitis	☐ Yes	□No	Glaucoma	☐ Yes	□No	Mononucleosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No	
Arthritis	☐ Yes	□No	Goiter	Yes	□No	Multiple Sclerosis	☐ Yes	☐ No	Suicide Attempt	Yes	□ No	
Asthma	☐ Yes	□ No	Gonorrhea	Yes	□ No	Mumps	☐ Yes	☐ No	Thyroid Problems	Yes	□ No	
Bleeding	☐ Yes	□ No	Gout	☐ Yes	□No	Osteoporosis	☐ Yes	☐ No	Tonsillitis	Yes	□ No	
Disorders		1-1/1/25	Heart Disease	☐ Yes	□No	Pacemaker	☐ Yes	☐ No	Tuberculosis	Yes	□ No	
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	□ No	Parkinson's	☐ Yes	☐ No	Tumors, Growths	Yes	□ No	
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	□No	Disease		- N-	Typhoid Fever	Yes	□ No	
Bulimia	☐ Yes	□No	Herniated Disk	☐ Yes	□No	Pinched Nerve	☐ Yes	□ No	Ulcers	☐ Yes	□ No	
Cancer	☐ Yes	□ No	Herpes	☐ Yes	□ No	Pneumonia	☐ Yes	□ No	Vaginal Infections	V-552.8	□ No	
Cataracts	☐ Yes	□No	High Cholesterol	☐ Yes	□ No	Polio Prostate Problem	Yes	□ No	Venereal Disease Whooping Cough		□ No	
Chemical Dependency	/ □ Yes	□No	Kidney Disease	☐ Yes	□No	Prosthesis	☐ Yes	□ No	Other Other			
EXERCISE WORK A		WORK A	CTIVITY HABITS									
□ None			Sitting		☐ Smoking			Packs/Day				
			☐ Standing	☐ Standing			Alcohol			Drinks/Week		
☐ Daily ☐ Light			☐ Light Labor			☐ Coffee/Caffeine Drinks			Cups/Day			
☐ Heavy Lab			or High Stress Level				Reason					
Are you pre	gnant? □ Y	′es □ N	lo Due Date									
Are you pregnant? Yes No Due Date Injuries/Surgeries you have had				Description				Date				
Falls												
Head	Injuries											
	n Bones											
Disloc												
Surge												
curgo					TES							
	MEDICA	TIONS	3		ALL	ERGIES	\ \	/ITAN	IINS/HERBS/M	IINER	ALS	
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									SYLE KEGIE			
					N.S.			-11-0			AU3E	
Pharmacy I	Name											
Pharmacy I	Phone (	)										