

Chiropractic Registration and History

1 Patient Information

Date: _____
 Patient: _____
 Address: _____

 City _____ State _____ Zip _____
 Sex: M _____ F _____ Age: _____ Birth Date: ____/____/____
 Single _____ Married _____ Widowed _____ Separated _____ Divorced _____
 Patient SS#: _____ - _____ - _____
 Occupation: _____
 Employer: _____
 Employer Address: _____

 Employer Phone: _____
 Spouse's Name: _____
 Birth Date: ____/____/____ -SS#: _____ - _____ - _____
 -Occupation: _____
 -Employer: _____
 Whom may we thank for referring you? _____

2 Insurance

Who is responsible for the account? _____
 Relationship to patient: _____
 Insurance Co.: _____
 Group #: _____
 Is patient covered by additional insurance? Yes _____ No _____
 Subscribers Name: _____
 Birth Date: ____/____/____ SS#: _____ - _____ - _____
 Relationship to patient: _____
 Insurance Co.: _____
 Group #: _____
ASSIGNMENT AND RELEASE
 I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Back in Line Chiropractic Center Inc., all insurance 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 Back in Line Chiropractic Center Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Also, Payment Now fees are to be paid at time of service.

 Responsible Party Signature

 Relationship _____ Date _____

3 Phone Numbers

Home: _____ Work: _____
 -Ext.: _____
 Cell Phone: _____
IN CASE OF EMERGENCY CONTACT:
 Name: _____ Relationship: _____
 Phone Number: _____

4 Accident Information

Is condition due to an accident? Yes _____ No _____
 Date: ____/____/____
 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) _____

5 Patient Condition

What is your major symptom/problem? _____

 When did the symptoms appear? _____

 Is this condition getting progressively worse? Yes _____ No _____ Unknown _____
 Have you noticed any visceral or neurological problems since the condition occurred?
 (For example: High blood pressure, loss of balance, numbness, etc. _____

● Mark an X on the picture where you continue to have pain, numbness, or tingling.
 Rate the severity of the pain on a scale from 1 (least pain) to 10 (most pain)
Type of pain: Sharp _____ Dull _____ Throbbing _____ Numbness _____ Aching _____ Radiating _____
 Shooting _____ Burning _____ Tingling _____ Cramps _____ Stiffness _____ Swelling _____
 Other _____
 How Often do you have the pain? _____
 Is it constant or does it come and go? _____
 Does it Interfere with your? Work _____ Sleep _____ Daily Routine _____ Recreation _____
 What makes your condition better? _____
 What makes your condition worse? _____
 Activities or movements that are painful to perform _____ Sitting _____ Standing _____ Walking _____ Bending _____
 Lying Down _____
 Is there a particular time of day that your problem is better or worse? _____

