

**NEW PATIENT REGISTRATION**

**Marital Status (Check One)**  Single  Divorced  Widow  Married

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Responsible Party/Relation:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_ **City** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Policy Holder:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **ID#:** \_\_\_\_\_ **Group#:** \_\_\_\_\_

**Policy Holder:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Job Title:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**PCP:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Specialist:** \_\_\_\_\_ **Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**MRI/CT Scans/X-Rays (Where performed):** \_\_\_\_\_ **When:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Is this accident related?** Y N **Type:** Motor Vehicle Work Comp Other \_\_\_\_\_ **Accident State:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Were you at fault?** Y N **Do you have a Liability?** Y N **Are you claiming it on No-Fault Insurance** Y N

**Auto Ins** \_\_\_\_\_ **Claim #** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Is there Med Pay available?** Y N **Policy limits:** \$ \_\_\_\_\_ **Agents Name:** \_\_\_\_\_

**Is there a Lien?** Y N **Attorney:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Workers Comp Carrier:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Case Worker:** \_\_\_\_\_ **Claim #:** \_\_\_\_\_ **Date of Injury:** \_\_\_\_\_ **Injury Site:** \_\_\_\_\_

*Did you sustain an injury at work?* Y N

*Are your injuries accident related?* Y N

*Are you currently employed?* Y N

*Are you covered under an employer or union policy?* Y N

*Is your spouse or other family member employed?* Y N

*Do you have a secondary insurance policy?* Y N

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers completely. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information as I know it is my responsibility to do so. I additionally agree that if my account is sent to collection due to failure to pay, I will be financially responsible for including a 35% collections fee, other collection fees, court costs, attorney fees and any other fees incurred due to my debt.

\_\_\_\_\_  
**Patient Signature/Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**

**For Internal Use Only**

**DEA:** \_\_\_\_\_ **Meds/Bottles:** \_\_\_\_\_ **CL:** \_\_\_\_\_ **Appt Date:** \_\_\_\_\_ **Appt Time:** \_\_\_\_\_ **Employee:** \_\_\_\_\_ **Length of Appt:** \_\_\_\_\_



Name \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date \_\_\_\_\_

Dominant Hand  Right  Left Marital Status (Check One)  Single  Divorced  Widow  Married  
 Occupation \_\_\_\_\_ Date symptoms began \_\_\_\_\_

Referring physician \_\_\_\_\_

List current symptoms \_\_\_\_\_

What treatment, if any, have you had for these symptoms? \_\_\_\_\_

Were you in an accident?  Yes  No If yes, what date? \_\_\_\_\_

What type of accident? \_\_\_\_\_

What treatment did you receive for this? Was there a hospitalization?  
 \_\_\_\_\_  
 \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

**MEDICAL HISTORY/REVIEW OF SYSTEMS**

<u>Disease or Disorder</u>	You	Family	<u>Disease or Disorder</u>	You	Family
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Vein Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Bowel	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Other Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Hypothermia	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Anesthesia Problems	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Other Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>

List all past operations, serious illnesses & hospitalizations, including dates:

\_\_\_\_\_ year: \_\_\_\_\_  
 \_\_\_\_\_ year: \_\_\_\_\_



\_\_\_\_\_ year: \_\_\_\_\_

List any **ALLERGIES** to medication, food, or **LATEX** and the reaction they cause

Medication	Reaction

List all medications you are currently taking. Please indicate dosage, times per day and reason for the medication. If none at this time, please state "None". Please include over the counter medications and herbal medications in this list:

Medication	Strength/Dosage	How do you take it?	How often?

Do you use alcohol  Yes  No What type? \_\_\_\_\_ How often? \_\_\_\_\_  
 Do you use tobacco  Yes  No What type? \_\_\_\_\_ How often? \_\_\_\_\_

**Family History**

Father Living?  Yes  No Siblings Living?  Yes  No  
 Children Living?  Yes  No Mother Living?  Yes  No

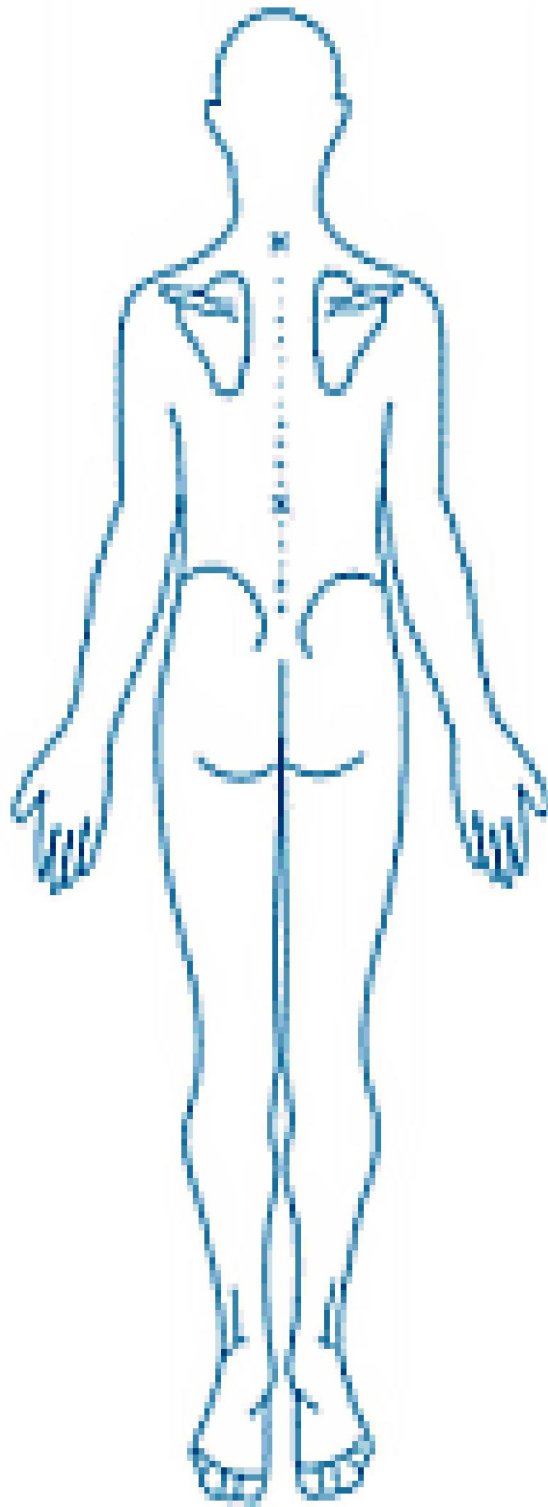
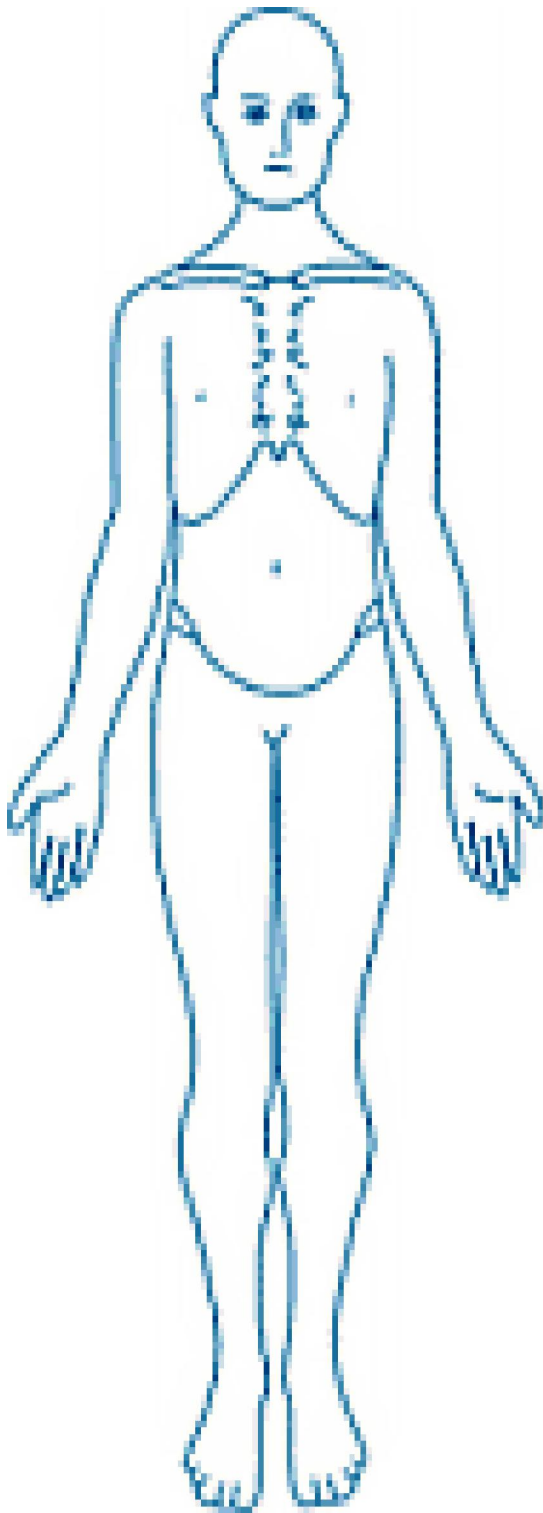
Are you taking any blood thinners? (Ex: Lovenox, Warfarin, Aggrenox, Plavix, Coumadin etc.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



Name \_\_\_\_\_ Birthdate: \_\_\_\_\_ Date \_\_\_\_\_

Using  
areas  
pain,



the  
diagram,  
identify all  
that have  
numbness,  
and/or  
tingling.