

PATIENT REGISTRATION – WELCOME!

B M

Patient Name _____ Today's Date _____

Address _____ City/St _____ Zip _____

DOB _____ Age _____ SS# _____ Sex: M / F Marital: M / S / D / W

Cell Ph # _____ Home Ph # _____ Work # _____

Email _____ Spouse's Name _____ # Children _____

Occupation _____ Employer _____

Emergency Contact _____ Ph # _____ Relation _____

Medical Doctor _____ Address _____ Ph # _____

Appt request date _____ Ref to Dr: Brown McClautherty How were you Referred? _____

Major Complaint(s) _____

Accident?: Auto? Y /N Work? Y /N Other? Y /N Accident date _____ Have you called an Atty? Y /N

If Auto, claim #: _____ Adjuster: _____ Ph # _____ Fax _____

Insurance: Carrier _____ Ph # _____

Policy# / Member ID# _____ Group # _____

Policyholder's Name _____ SS# _____ DOB _____

Claims Address _____ City/St _____ Zip _____

For Office Use Only In Network? Y / N Plan type: PPO / HSA-HRA / HMO / EPO / PIP / ACN

Policy Effect date _____ Cal Yr/Other _____ Pre-exist clause? Y /N: exp date: _____

Filing Deadline? _____ Referral Required? Y / N HSA/HRA Balance: \$ _____

Exam: Deduct? _____ Applied? _____ Copay? _____ Payor Percent? _____

Manip: Deduct? _____ Applied? _____ Copay? _____ Payor Percent? _____

Therapy: Deduct? _____ Applied? _____ Copay? _____ Payor Percent? _____

X-ray: Deduct? _____ Applied? _____ Copay? _____ Payor Percent? _____

Limitations: Ofc Visit # _____ Max Dollar Cap \$ _____ Units/visit? _____ 98941=Unit? Y /N

Acu 97810? Y /N \$ _____ DTS S9090? Y /N \$ _____ Laser S8948? Y /N \$ _____

Max OOP _____ /met _____ Other _____

Rep spoke with _____ Today's Date _____ Your Init: _____

The above coverage information was obtained from your carrier as a courtesy to you. This is not a guarantee of payment from your insurance carrier. Due to the inaccuracy of insurance companies relaying this information, it is your responsibility to verify the above information and inform us of any conflicts. In the event that we are unable to collect from your carrier in a timely manner, we may send you a bill and ask for your assistance. I _____, agree that I am ultimately responsible for payment of any balances on my account and will help handle any negotiations with my carrier, or any other involved parties, that may be needed to settle my account. I also agree to pay for any treatment considered in excess and/or in exclusion of my carrier coverage.

Patient Signature : _____ Date: _____

Prior Treatment for Current Problem

Have you seen anyone else for these symptoms? Y / N Who? _____ Dates: _____

What did they recommend? _____ Medications: _____

Test Results for: X-ray _____ CT/MRI _____

Lab _____ Other _____

Injections: Epidural Facet Other _____ Results: Better No change Worse

Surgery: Year/Type _____ Results: Better No change Worse

Chiropractic: Year/Type _____ Results: Better No change Worse

PT/Other Treatment: Year/Type _____ Results: Better No change Worse

Family Medical History: Anemia Arthritis Diabetes Heart disease High blood pressure

Lupus Cancer Psoriasis Scoliosis Drug allergies Muscle disease Rheumatoid Arthritis

Living Parents? Mother? Y / N: Died at age ____ of _____

Father? Y / N: Died at age ____ of _____

Your Medical History:

- GERD Heart disease Scoliosis Prostate problems
- Anemia Diabetes Hepatitis Lung disease Diverticulitis Lupus Polio
- Arthritis Glaucoma High BP Kidney disease Tuberculosis Migraine headaches
- Asthma Sinus trouble Lupus Thyroid disease Depression Joint replacement
- Cancer AIDS/HIV STD Muscle disease Alcoholism Stroke Seizures
- Ulcers WOMEN ONLY: Is there a possibility you may be pregnant? Y / N / Uncertain

Current Work Status:

Regular Duty Limited/Light Duty: Date began: _____ Off Work: Date began: _____

Lifestyle Habits:

Tobacco ____ (# cigs/day) Sleep ____ (hrs/day) Current exercise ____ (hrs/week)

Alcohol ____ (# drinks/day) Caffeine beverages ____ (# drinks/day)

List Current medications: _____

Drug Allergies: No Yes: _____

Surgeries/Hospitalizations/Fractures/Dislocations:

_____ Year: _____	_____ Year: _____
_____ Year: _____	_____ Year: _____
_____ Year: _____	_____ Year: _____

Have you ever been unconscious? No Yes: When/How? _____

Have you had any of the following recently? (Please check all that may apply):

- | | |
|---|---|
| Constitutional: <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats | Endocrine: <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Unexplained weight loss | Hematological: <input type="checkbox"/> Bruise easily |
| Eyes: <input type="checkbox"/> Abrupt changes of vision | Immunologic: <input type="checkbox"/> Allergies to pollen, etc. |
| Ears, Nose, Throat: <input type="checkbox"/> Abrupt changes in hearing | Genitourinary: <input type="checkbox"/> Burning/painful urination |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Loss of bladder/bowel control |
| <input type="checkbox"/> Sore throat <input type="checkbox"/> Deafness | <input type="checkbox"/> Frequent urination |
| Cardiovascular: <input type="checkbox"/> Chest pain <input type="checkbox"/> Poor circulation | Infection (recent): <input type="checkbox"/> Urinary tract <input type="checkbox"/> Respiratory |
| Respiratory: <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Immune system dysfunction |
| Gastrointestinal: <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting | <input type="checkbox"/> Skin <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoid | Psychosocial: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety |
| Musculoskeletal: <input type="checkbox"/> Pain/swollen joints | <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Fatigue |
| Skin: <input type="checkbox"/> Rash | Female: <input type="checkbox"/> Excessive menstrual flow |
| Neurological: <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness | <input type="checkbox"/> Cramps or backache |
| <input type="checkbox"/> Muscle weakness | |