Patient Registration Form/ Personal History

Dear Patient: <u>This information</u> is considered confidential. Because we care, this information will help us determine if the treatment offered here will help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form. Thank you. **PLEASE PRINT.**

PERSONAL:

Name: _____ Sex:___ Marital Status: ___ Date of Birth: _____ Today's Date: _____
(first, middle initial and last name) M or F S,M,D,W month/day/year

Address: _____ Zip Code: _____
(include street type such as St., Ave., Blvd., etc.) city state

Home Phone Number: (_____) _____ Social Security Number: _____-_____-_____

Employer's Name: _____ Employer's Address:_____

Business Phone Number (_____) _____ Your Occupation: _____

Spouse Name : _____ Spouse Date of Birth: _____ Social Security Number: _____
(first, middle initial and last name) month/day/year

Spouse's Employer's Address (City, State, Zip): _____

Who referred you to our office?_____ May we contact with person to say thank you? Yes No

Please describe the principal health problems for which you came to this office. _____

_____

Duration of this condition: _____ What are your treatment goals?_____

_____

FEMALES ONLY: When was your last period? _____ Are you pregnant? Yes No Maybe

PERSONAL IDENTIFICATION:

Drivers License #: _____ State:____ Do you have VISA, MASTERCARD, DISCOVER? _____ Exp Date:_____

Other I.D. (Check Guarantee, Credit Card): _____ VISA/MC/DISC Account No. _____

Name, address are relationship of nearest relative:_____

HEALTH INSURANCE:

Name of Medical Insurance: _____ Billing Address:_____

Phone Number: (_____) _____ Policy Number: _____

Insured Name: _____ Insured DOB: _____

AUTOMOBILE (NON-WORK RELATED) ACCIDENT:

Date of Injury/ Accident: _____ Vehicle Type:_____ Property Damage: $_____
month/day/year

Automobile Insurance: _____
(Name, adjustor's name, billing address)

Phone Number: (_____) _____ Automobile Insurance Policy Number:_____

Do you have an attorney **<u>who has advised you</u>** in this case? Yes No

If yes, list the name, address and telephone number: _____

WORK-RELATED ACCIDENT OR INJURY:

Have you notified your employer? Yes No If yes, who or what department? _____

Date of Injury: _____ Time: _____ AM PM Date last worked: _____

Injured at: _____
(address, city, county and state)

Do you have an attorney **who has advised you** in this case? Yes No

If yes, list the name, address and telephone number:_____

What is the name of your company's worker's compensation insurance carrier? _____

Adjuster's Name: _____ Phone Number: (_____) _____