

Chiropractic Registration and History

Patient Information

Date _____

Patient _____
First Middle Initial Last

Address _____

City State Zip

E-mail _____

Sex: M F Age _____ Birthdate _____

Married Widowed Single Minor

Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Phone Numbers

Home (_____) _____ Cell (_____) _____

Work (_____) _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone (_____) _____ Work Phone (_____) _____

Patient Condition

Reason for visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness or tingling

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

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

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

Insurance

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group# _____

Is patient covered by additional insurance? Yes No

Subscriber's Name` _____

Birthdate _____

Relationship to Patient _____

Insurance Co _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with _____

and assign directly to Dr. Gene Aiello, D.C. 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 the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance 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.

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Date Relationship to Patient

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) _____



