Family Chiropractic Center

Registration and History

Whom may we thank for referring you to us? _____

Is this visit due to an accident? YES NO

1. Patient Information

Patient Name: _____
Last First Middle Initial

Billing Address: _____
Number/Street City State Zip

Birthdate: _____ Email: _____
SS#: _____ Sex: Male / Female

Employer or School: _____ Occupation: _____
Employer/School Address: _____ Phone: _____

Spouse's Name: _____ Birthdate: _____
Spouse's Employer: _____ Phone: _____

2. Phone Numbers

Cell Phone (____) _____ Home/Work Phone (____) _____
Appointment Reminder: Call Text Email

IN CASE OF EMERGENCY, CONTACT
Name: _____ Relationship: _____
Cell Phone (____) _____ Home/Work Phone (____) _____

3. Insurance Information (Initial the relevant section)

_____**Insurance**: I certify that I, and or my dependent(s), have insurance coverage. If your insurance covers Chiropractic care, we will bill your insurance directly. We will require a copy of your insurance card on or before your second visit. Family Chiropractic Center may use your health care information and may disclose such information to your 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. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

_____**Cash**: Fee are to be paid at the time services are rendered, unless special arrangements have been made. Fee's will be approved and decided on by the doctor.

_____**Auto Injury**: You need to supply us with the accident report, your car insurance, health insurance and liable parties' insurance; attorney if applicable. We will bill your insurance directly after verifying coverage. I authorize Family Chiropractic Center to file a medical lien against any applicable third-party insurance settlement pursuant to RCW 60.44.010, et seq. I understand and acknowledge that in the event a medical lien if filed, and that if the lien is paid or settled, I will be provided with an original, written Satisfaction of Lien and I am responsible for filing the Satisfaction of Lien with the County Auditor and for paying the filing fee costs associated with filing any such Satisfaction of Lien.

_____**Work Injury**: You will need to report your accident to your employer, bring in necessary insurance information and sign the Report of Accident by your second visit.

_____**Medicare**: Per established Medicare guidelines please bring us your Medicare information on or before your second visit. We will bill your Medicare directly. Medicare only pays for covered items and services when Medicare rules are met. If Medicare does not pay for all of your health care item costs, you might have to pay for them yourself.

If you are uncertain about your Chiropractic medical coverage, please contact your insurance company. We will try our best to help you in any way we can.

4. Health History

What treatment have you already received for your condition? ~Medications ~Surgery ~Physical Therapy ~Chiropractic Services ~None ~Other: _____

Name and address of other doctor(s) who have treated you for your condition: _____

_____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____
Spinal Exam _____ Chest X-Ray _____ Urine Test _____
Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Check only those conditions which are applicable:

- o AIDS/HIV
- o Alcoholism
- o Allergy Shots
- o Anemia
- o Anorexia
- o Appendicitis
- o Arthritis
- o Asthma
- o Bleeding Disorders
- o Breast Lump
- o Bronchitis
- o Bulimia
- o Cancer
- o Cataracts
- o Chemical Dependency
- o Chicken Pox
- o Depression
- o Diabetes
- o Emphysema
- o Epilepsy
- o Fractures
- o Glaucoma
- o Goiter
- o Gonorrhea
- o Gout
- o Heart Disease
- o Hepatitis
- o Hernia
- o Herniated Disc
- o Herpes
- o High Cholesterol
- o Kidney Disease
- o Liver Disease
- o Measles
- o Migraine Headaches
- o Miscarriage
- o Mononucleosis
- o Multiple Sclerosis
- o Mumps
- o Osteoporosis
- o Pacemaker
- o Parkinson's Disease
- o Pinches Nerve
- o Pneumonia
- o Polio
- o Prostate Problems
- o Prosthesis
- o Psychiatric Care
- o Rheumatoid Arthritis
- o Rheumatic Fever
- o Scarlet Fever
- o Stroke
- o Suicide Attempt
- o Thyroid Problems
- o Tonsillitis
- o Tuberculosis
- o Tumors, Growths
- o Typhoid Fever
- o Ulcers
- o Vaginal Infections
- o Venereal Disease
- o Whooping Cough
- o Other _____ _____ _____

Dates of last exams: _____

Are you pregnant? YES/NO Nursing: YES/NO Taking birth control pills? YES/NO

List any types of surgeries which you have had, and the dates which they occurred: _____

_____

Do you have any allergies? _____

5. Daily Habits

What type of exercise do you perform on a daily basis? _____

What do your daily work habits include? (ex. sitting, standing, light labor, heavy labor, computer work) _____

_____

Do you smoke? YES/NO How much per day? _____

How much liquor do you consume on a weekly basis? _____

How much coffee or caffeinated beverages do you consume on a daily basis? _____

6. Medications

What vitamins do you currently take? _____

What kind of other nutritional supplement do you take (if any)? _____

Please list all prescribed and non-prescribed medications you are currently taking: _____

_____

Patient's Name: _____

Signature: _____ Date: _____