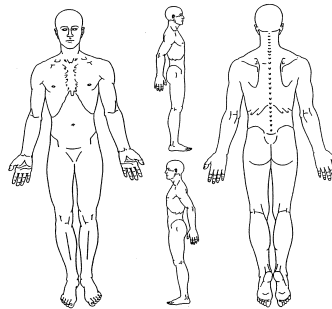


PATIENT REGISTRATION FORM

NAME			HOME #		
ADDRESS			WORK #		
CITY-STATE-ZIP			CELL #		
EMERGENCY CONTACT		PHONE #	SS #		E-MAIL
<input type="radio"/> MALE <input type="radio"/> FEMALE	<input type="radio"/> OS <input type="radio"/> OM <input type="radio"/> OD <input type="radio"/> OW	DATE OF BIRTH		DRIVER LICENSE #	
EMPLOYER			OCCUPATION		
ADDRESS			CITY-STATE-ZIP		
REFERRED BY			PRIVATE PHYSICIAN		

PLEASE INDICATE REGION OF COMPLAINT

<input type="radio"/> HEADACHE PAIN
<input type="radio"/> NECK PAIN
<input type="radio"/> UPPER/MID BACK PAIN
<input type="radio"/> LOW BACK PAIN
<input type="radio"/> SHOULDER-ELBOW-WRIST-HAND PAIN
<input type="radio"/> HIP-KNEE-ANKLE-FOOT PAIN
<input type="radio"/> OTHER



USE THE LETTERS LISTED BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR PAIN AND SENSATIONS...

KEY

- A = ACHE
- B = BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES

MEDICAL HISTORY

	YES	NO	
<input type="checkbox"/> ARTHRITIC CONDITION	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> LIST MEDICATIONS
<input type="checkbox"/> CANCER	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> DIABETES	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> HEART PROBLEMS	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> ALLERGIC TO MEDICATIONS
<input type="checkbox"/> VASCULAR CONDITION	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> LUNG PROBLEMS	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> USUAL CHILDHOOD DISEASES	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> ALLERGIES
<input type="checkbox"/> UNUSUAL CHILDHOOD DISEASES	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> CURRENTLY PREGNANT	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> EXERCISE REGULARLY	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> HEIGHT
<input type="checkbox"/> SMOKER	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> WEIGHT
<input type="checkbox"/> ALCOHOL	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> LIST SURGERIES / HOSPITALIZATIONS
<input type="checkbox"/> ALLERGIES	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> BIRTH CONTROL MEDICATIONS	<input type="radio"/>	<input type="radio"/>	-
<input type="checkbox"/> OTHER			

SPECIFIC INJURY? <input type="radio"/> YES <input type="radio"/> NO	DATE OF INJURY
PREVIOUS TREATMENT? <input type="radio"/> YES <input type="radio"/> NO	TREATMENT TYPE
DOCTOR NAME	PHONE #
NATURE OF INJURY <input type="radio"/> AUTO <input type="radio"/> WORK RELATED <input type="radio"/> HOME / OTHER	COMPLETE SECTIONS 1 & 3 ONLY COMPLETE SECTIONS 2 & 3 ONLY COMPLETE SECTION 3 ONLY

SECTION #1 – PERSONAL INJURY

DATE	TIME	OAM	OPM	LOCATION OF ACCIDENT
<input type="radio"/> AUTO V AUTO	<input type="radio"/> AUTO V TRUCK	<input type="radio"/> MOTORCYCLE		<input type="radio"/> AUTO V BUS
<input type="radio"/> AUTO V PEDESTRIAN	<input type="radio"/> SLIP & FALL	<input type="radio"/> OTHER		
PLEASE DESCRIBE INJURY				
<input type="radio"/> DRIVER OR <input type="radio"/> PASSENGER	<input type="radio"/> FRONT SEAT OR <input type="radio"/> BACK SEAT	WEARING SEAT BELT OR SHOULDER HARNESS?	<input type="radio"/> YES <input type="radio"/> NO	
BODY PARTS STRUCK	<input type="radio"/> YES <input type="radio"/> NO	IF YES, PLEASE LIST		
EMERGENCY TREATMENT?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, WHERE?		
WORK –RELATED?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, ANY WORK LOSS?	<input type="radio"/> YES <input type="radio"/> NO	
LOSS OF CONSCIOUSNESS?	<input type="radio"/> YES <input type="radio"/> NO	WERE YOU BLEEDING?	<input type="radio"/> YES <input type="radio"/> NO	
X –RAY TAKEN?	<input type="radio"/> YES <input type="radio"/> NO	IF YES, LIST AREAS		

SECTION #2 –WORKERS’ COMPENSATION INJURY / EMPLOYER INFORMATION

COMPANY NAME			
ADDRESS			
CITY-STATE-ZIP			
TYPE OF BUSINESS			
OCCUPATION			
DATE OF INJURY	TIME OF INJURY	OAM / OPM	DATE LAST WORKED
DESCRIBE INJURY			
INJURED AT [LOCATION-STREET-CITY-STATE-ZIP]			

SECTION #3 – INSURANCE INFORMATION / METHOD OF PAYMENT

<input type="radio"/> CASH <input type="radio"/> CREDIT CARD	<input type="radio"/> CHECK	<input type="radio"/> GENERAL HEALTH INSURANCE	<input type="radio"/> WORKERS’ COMPENSATION INSURANCE	<input type="radio"/> AUTO INSURANCE
INSURANCE COMPANY			CLAIM REPRESENTATIVE	
POLICY #	GROUP #		CLAIM #	
ADDRESS				
CITY-STATE-ZIP			PHONE #	
NAME OF INSURED			SS #	<input type="radio"/> SELF <input type="radio"/> OTHER
AUTO MED –PAY INSURANCE COMPANY			POLICY #	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION / FINANCIAL AGREEMENT

<p>I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY TO DOCUMENT MY CLAIM FOR BENEFITS. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF ALL CHARGES FOR MY TREATMENT. SERVICES ARE PAYABLE AT THE TIME RENDERED.</p>	
<p>_____</p> <p>PATIENT OR GUARDIAN SIGNATURE</p>	<p>_____</p> <p>DATE</p>