

Chiropractic Sports Medicine

NEW PATIENT REGISTRATION FORM

(Please Print)

Today's date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Sin / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose clinic/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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PATIENT HISTORY AND INFORMATION

Purpose for this appointment: _____

Present Complaints (please circle the appropriate ones)

Headache
Migraines
Ears ringing/buzzing
Dizziness
Unbalanced
Shortness of breath
Neck pain/stiffness
Pain radiating in R/L arm
Pain radiating into skull

Upper back pain
Upper back stiff
Midback pain/stiffness
Pins and needles in R/L arm
Chest pain
Pins and needles in R/L leg
Rib pain
Pain radiating in R/L leg
Pain radiating into ribs

Constipation
Feet/Hands cold
Sciatica
Pins and needles in R/L hand
Double vision
Pins and needles in R/L foot
Low back pain/stiffness
Pain radiating into neck
Pain radiates in shoulder

Do you have difficulty with: Standing Sitting Bending Twisting Walking

Cannot lift: Light Moderate Heavy Repetitive

When and how did these symptoms appear? _____

Have you ever had the same or similar condition: Yes or No

Please rate your symptoms on a scale of 1-10, where 10 is the worst pain:
 1 2 3 4 5 6 7 8 9 10

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing

How frequent is this condition? Constant Daily Intermittent Night only

What makes the pain or symptoms better? _____

What makes the pain or symptoms worse? _____

List any doctors/specialists that you have seen for this complaint: _____

Relevant medical history: (Please circle conditions you have or have had previously)

Arthritis	Epilepsy	Muscular Dystrophy
Asthma	Fibromyalgia	Neck pain or spasm
Anemia	Hand or wrist pain	Neuritis
Back pain or spasm	Headaches	Numbness
Cancer	Heart problems	Osteoporosis
Concussion	Hepatitis	Rheumatic Fever
Convulsion	High blood pressure	Sinus Trouble
Diabetes	HIV	Sciatica
Digestion problems	Measles	Tuberculosis
Dizziness	Multiple Sclerosis	Venereal Disease

List any operations that you've had and approximate dates: _____

Have you had any broken bones: _____

List any major accidents other than those above: _____

Are you allergic to any medication(s): _____

Are you taking any medication: _____

Do you: Drink Alcohol Exercise Smoke

WOMEN ONLY:

Are you pregnant: Yes or No For how long? _____

Fees are payable at the time X-rays, examinations, and treatments are rendered, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Authorization and Release:

I hereby instruct the above named Insurance Company to pay by check made out to and mailed directly to:

Chiropractic Sports Medicine
24741 Alicia Parkway Suite D
Laguna Hills, CA 92653
(949) 951 - 1160

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check to me and mail it as follows:

Chiropractic Sports Medicine
24741 Alicia Parkway Suite D
Laguna Hills, CA 92653
(949) 951 - 1160

For professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this Assignment shall be considered as effective and valid as the original.

If there is anyone you do not want to receive your medical records, please inform our office.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Chiropractic Sports Medicine or insurance company to release any information required to process my claims.

Patient/Guardian signature: _____

Date: _____

_____/_____/20____