Registration

Name: _____ Preferred Name: _____

DOB: _____ / _____ / _____ Age: _____ Sex: ☐ Male ☐ Female

Mailing Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ How did you hear about us: _____

Employed: ☐Yes ☐No ☐Retired ☐Disabled Occupation: _____

Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Domestic Partner ☐Other_____ Spouse's Name: _____

Medical/Insurance Information-

Primary Insurance-

Insurance Co.: _____

Group #: _____

Subscriber ID: _____

Insured's Name: _____

Insured's Employer:_____

Insured's SS#: _____

Relation: _____ DOB: _____

Secondary Insurance-

Insurance Co.: _____

Group #: _____

Subscriber ID: _____

Insured's Name: _____

Insured's Employer: _____

Insured's SS#: _____

Relation: _____ DOB: _____

Guarantor- (if same as patient, just leave blank)

Name: _____ Relation: _____ DOB: _____

Billing Address: _____

Driver's License State and #: _____ Phone: _____

Emergency Contact-

Name: _____ Relation: _____ Phone: _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Signed: _____ Date: _____

Confidential Health Questionnaire

Name: _____ DOB: _____

Medical History

Have you ever received a chiropractic treatment? □ Yes □ No If yes, how long ago?_____

Are you currently under medical care for any disease/condition? □ Yes □ No Please Explain: _____

Have you ever:	Yes	No	Date	If yes, briefly explain.
- had a broken bone?	□	□	_____	_____
- been hospitalized?	□	□	_____	_____
- had strains or sprains?	□	□	_____	_____
- been struck unconscious?	□	□	_____	_____
- had a motor vehicle accident?	□	□	_____	_____
- had a surgical procedure?	□	□	_____	_____

Please list any minerals, herbs or vitamins you take: _____

Please list all prescription and over the counter medications you currently take (Birth Control Pills, Pain Killers, etc):_____

_____

	None	Light	Mod	Heavy		None	Light	Mod	Heavy
Water	□	□	□	□	Sugar	□	□	□	□
Soft Drinks	□	□	□	□	Stress	□	□	□	□
Coffee/Black Tea	□	□	□	□	Sleep	□	□	□	□
Alcohol	□	□	□	□	Appetite	□	□	□	□
Tobacco	□	□	□	□	Exercise	□	□	□	□

Please indicate if you have any or have had any of the following conditions:

Cardiovascular
- □ Heart Attack
- □ High blood pressure
- □ Low blood pressure
- □ Pacemaker/defibrillator
- □ Other: _____

Gastrointestinal
- □ Colitis
- □ Irritable bowel syndrome
- □ Ulcers
- □ Other: _____

Respiratory
- □ Asthma
- □ Bronchitis
- □ Difficulty breathing
- □ Pneumonia
- □ Tuberculosis
- □ Other: _____

Skin
- □ Bruise easily
- □ Hives or allergy
- □ Varicose veins
- □ Eczema/Psoriasis
- □ Other: _____

Ear, Nose & Throat
- □ Deafness
- □ Frequent earache/infection
- □ Enlarged thyroid
- □ Sinus infection

Musculoskeletal
- □ Arthritis
- □ Bursitis
- □ Hernia
- □ Multiple Sclerosis
- □ Spinal Curvature/Scoliosis`
- □ Other: _____

General/Other
- □ Anemia
- □ Cancer: _____
- □ Diabetes I or II Onset: _____
- □ Implants (pins, plates, port, etc)
- □ Insomnia
- □ Epilepsy
- □ Migraines/Headaches
- □ Depression
- □ Anxiety
- □ Other: _____

Women
- # of pregnancies: _____
- # of children: _____
- □ Pregnant - How many weeks: _____

Current Complaint

If you have no symptoms or complaints, and are here for wellness care, please check the box and sign at the bottom of the page. □

Please list your current complaints in order of importance:
1. _____
2. _____
3. _____

Your primary complaint is a result of: □ Work □ Sports □ Auto accident □ Trauma □ Chronic □ Other: _____

Please explain what happened:
_____
_____

Would you describe the pain as: □Sharp/stabbing □Dull ache □Stiff/tightness □Numbness □Tingling □Burning

Rate your pain: 0 1 2 3 4 5 6 7 8 9 10

When did it begin? _____ Is it getting worse? □Yes □No Have you experienced this before? □Yes □No

Does anything make it better? _____

Does anything make it worse? _____

Have you sought other treatment for this condition? □Yes □No Describe the treatment: _____
_____

Did the other treatment(s) help? □Yes □No Explain: _____

If you have any other complaints please describe them here: _____
_____
_____
_____

I acknowledge that I have answered all the questions herein to the best of my knowledge, and I understand that it is my responsibility to inform the doctor of any changes to my health.

_____ _____
Signature Date

Financial Policy and HIPAA Privacy Policy Acknowledgement

Patient Name:_____ Date: _____

・By signing below, I acknowledge that I have received, read, understand and agree to the Summit to Shore Chiropractic Financial Policy.

Patient Signature: _____

・By signing below, I acknowledge that I have received, read, understand and agree to the Summit to Shore Chiropractic HIPAA Notice of Privacy Practices.

Patient Signature: _____