PATIENT REGISTRATION

Today's Date:

PATIENT INFORMATION

Name:

Name Preferred to Be Called:

Date of Birth:

Social Security #:

Mailing Address:

City, State, Zip:

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Home Phone #:

Cell Phone #:

Work Phone #: Ext:

Email Address:

Referred To Us By:

PRIMARY CARE PHYSICIAN

Primary Care Physician:

Street Address:

City, State, Zip:

Facility Name:

Phone #:

Fax #:

INSURANCE INFORMATION

Primary Insurance:

Subscriber's Name:

Subscriber's Birthday:

Policy No:

Relationship to Subscriber:
☐Self ☐Spouse ☐Dependant ☐Other

Subscriber's Employer:

Employer's Address:

City, State, Zip:

Employer's Phone #: Ext.

Secondary Insurance:

Subscriber's Name:

Subscriber's Birthday:

Policy No:

Relationship to Subscriber:
☐Self ☐Spouse ☐Dependant ☐Other

Subscriber's Employer:

Employer's Address:

City, State, Zip:

Employer's Phone #: Ext.

IN CASE OF EMERGENCY

Please Contact:

Relationship to Patient:

Home Phone #:

Alternate Phone #:

Assignment & Release *- By signing below, I authorize Chester Chiropractic Office to release medical records required by my insurance company(s) to obtain precertification or payment. I authorize my insurance company(s) to pay benefits directly to Chester Chiropractic Office and I agree that a reproduced copy of this authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance, or any amount for a patient for which I am the guarantor. I agree that I will be responsible for any collection agency or attorney fees incurred due to non-payment on this account. I understand that by signing below, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations.*

Patient / Guardian

Date

PATIENT HEALTH HISTORY

If you are presently troubled by a particular condition or have ever had a listed condition in the past, please check it in the Yes column. The information you provide concerning past and present conditions assist your doctor in more thoroughly understanding your state of health. This questionnaire is completely confidential and will not be released without your specific consent

Yes	No	
___	___	Neck Pain (723.1)
___	___	Shoulder Pain (719.41)
___	___	Pain in ☐ Upper Arm or ☐ Elbow (719.42)
___	___	Hand Pain (719.44)
___	___	Wrist Pain (719.43)
___	___	Upper Back Pain (724.1)
___	___	Low Back Pain (724.2)
___	___	Pain in ☐ Upper Leg or ☐ Hip (719.45)
___	___	Pain in ☐ Lower Leg or ☐ Knee (729.5)
___	___	Pain in ☐ Ankle or ☐ Foot (719.47)
___	___	Jaw Pain (526.9)
___	___	Joint ☐ Swelling (719.0) / ☐ Stiffness (719.5)
___	___	Fainting (780.2)
___	___	Visual Disturbances (728.9)
___	___	Convulsions (780.3)
___	___	Dizziness (780.4)
___	___	Headache (784.0)
___	___	Muscular Incoordination (781.3)
___	___	Tinnitus (Ear Noises) (388.30)
___	___	Rapid Heart Beat (785.0)
___	___	Chest Pain (786.50)
___	___	Loss of Appetite (783.0)
___	___	Irritable Colon (564.1)
___	___	Excessive Thirst (783.5)
___	___	Chronic Cough (786.2)
___	___	Chronic Sinusitis (473.9)
___	___	General Fatigue (780.7)
___	___	Irregular Menstrual (626.4)
___	___	Profuse Menstrual (611.72)
___	___	Breast ☐ Soreness / ☐ Lumps (611.72)
___	___	Endometriosis (617.9)
___	___	PMS (625.4)
___	___	Loss of Bladder Control (788.30)
___	___	Painful Urination (788.1)
___	___	Frequent Urination (788.41)
___	___	Abdominal Pain (789.0)
___	___	☐ Constipation / ☐ Irregular Bowel Habits (564.0)
___	___	Difficulty Swallowing (787.2)
___	___	☐ Heartburn / ☐ Indigestion (787.1)
___	___	☐ Dermatitis / ☐ Eczema / ☐ Rash (692.9)
___	___	Depression (311.9)

Yes	No	
___	___	Do You Have A Permanent Disability Rating?

Area of the Body Affected: ____________________

Date Rating Received: ____________________

Rating Percentage: ____________________

Immediate Family Medical History

___	Cancer (V16)	___	Chronic Back Problems (V17.89)
___	Heart Problems (V17.4)	___	Chronic Headaches (V19.8)
___	Lung Problems (V17.6)	___	High Blood Pressure (V17.49)
___	Diabetes (V18.0)	___	Rheumatoid Arthritis (V17.7)
___	Epilepsy (V17.2)	___	Other Condition(s): __________
___	Lupus (V19.8)		____________________

Yes	No	
___	___	Aortic Aneurysm (441.5)
___	___	High Blood Pressure (401.9)
___	___	Angina (413.9)
___	___	Heart Attack (411.0)
___	___	Stroke (436.9)
___	___	Asthma (439.9)
___	___	Cancer ☐ Past (V10) ☐ Present (199.1)
___	___	Tumor (229.9)
___	___	Prostate Problems (601.9)
___	___	Blood Disorder (790.6)
___	___	Emphysema (Chronic Lung Disorders) (492.8)
___	___	Arthritis (716.9)
___	___	Rheumatoid Arthritis (714.0)
___	___	Diabetes ☐ Type I (250.01) ☐ Type II (250.00)
___	___	Epilepsy (349.5)
___	___	Ulcer (556.9)
___	___	☐ Liver (573.9) / ☐ Gallbladder Problems (575.9)
___	___	Kidney Stones (592.0)
___	___	Hepatitis (573.3)
___	___	Bladder Infection (595.9)
___	___	Kidney Disorders (V11.03)
___	___	Colitis (558.9)
___	___	Abnormal Weight ☐ Gain (783.1) / ☐ Loss (783.2)
___	___	HIV (V08) /AIDS (042)
___	___	Anorexia (307.1)
___	___	Systemic Lupus (710.0)
___	___	Other ____________________

Yes	No	
___	___	Tobacco ☐ Present (305.1) ☐ Past (V15.82)
___	___	Alcohol If Yes, Frequency: __________
___	___	☐ Drug / ☐ Alcohol Dependence (V11.3/303.99)
___	___	☐ Coffee / ☐ Tea / ☐ Caffeinated Soft Drinks Servings per Day: __________
___	___	Hospitalization / Surgeries: __________
___	___	Prior Accidents/Injuries: __________
___	___	Current Medications (Rx, OTC, Vitamins): __________

Please List Any Known Allergies: ____________________

Weight ________lbs **Height** ____Ft ____In

For Women

Yes	No	
___	___	Are You On Any Form Of Birth Control?
___	___	Are You Nursing?
___	___	Are You Or Could You Be Pregnant?

If Yes, How Far Along? ____________________

If No, Last Period? ____________________

______________________________ Patient Signature

______________________________ Date

Donald Littlejohn, DC ~ Chester Chiropractic Office ~ 7 Academy Avenue, Chester NY 10918
Phone (845) 469-7575 ~ Fax (845) 469-9328 ~ Emergency (845) 987-2840

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name: Last ______ First ______ MI ______

◯ Female ◯ Male

Patient date of birth: ___ / ___ / ______

Patient address ______ City ______ State ______ Zip code ______

Patient insurance ID# ______ Health plan ______ Group number ______

Referring physician (if applicable) ______ Date referral issued (if applicable) ______ Referral number (if applicable) ______

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) ______
2. Federal tax ID(TIN) of entity in box #1 ______
3. Name and credentials of the individual performing the service(s) ______
   1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ______
4. Alternate name (if any) of entity in box #1 ______
5. NPI of entity in box #1 ______
6. Phone number ______
7. Address of the billing provider or facility indicated in box #1 ______
8. City ______
9. State ______
10. Zip code ______

Provider Completes This Section:

Date you want *THIS* submission to begin: ___ / ___ / ______

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery ___ / ___ / ______

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other ______

Diagnosis (ICD code)

Please ensure all digits are entered accurately

1° ___ ___ ___ • ___ ___
2° ___ ___ ___ • ___ ___
3° ___ ___ ___ • ___ ___
4° ___ ___ ___ • ___ ___

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

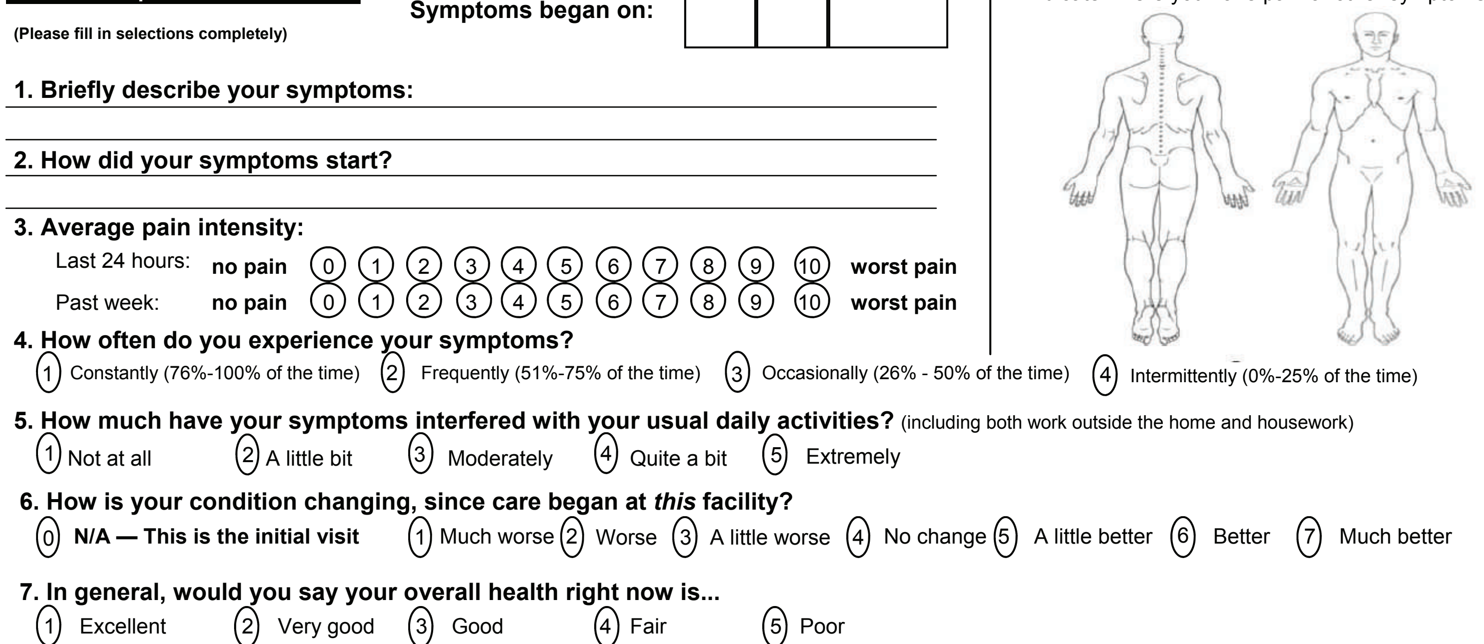
DC ONLY

Anticipated CMT Level

◯ 98940 ◯ 98942
◯ 98941 ◯ 98943

Current Functional Measure Score

Neck Index ______ DASH ______ ______ (other) ______
Back Index ______ LEFS ______



Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on: ___ / ___ / ______

Indicate where you have pain or other symptoms:

1. Briefly describe your symptoms: ______

2. How did your symptoms start? ______

3. Average pain intensity:

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

4. How often do you experience your symptoms?

1. Constantly (76%-100% of the time)
2. Frequently (51%-75% of the time)
3. Occasionally (26% - 50% of the time)
4. Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

6. How is your condition changing, since care began at *this* facility?

0. **N/A — This is the initial visit**
1. Much worse
2. Worse
3. A little worse
4. No change
5. A little better
6. Better
7. Much better

7. In general, would you say your overall health right now is...

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Patient Signature: X ______________________ **Date:** ______________