

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 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 <input type="checkbox"/> Upper Arm or <input type="checkbox"/> Elbow (719.42)
___	___	Hand Pain (719.44)
___	___	Wrist Pain (719.43)
___	___	Upper Back Pain (724.1)
___	___	Low Back Pain (724.2)
___	___	Pain in <input type="checkbox"/> Upper Leg or <input type="checkbox"/> Hip (719.45)
___	___	Pain in <input type="checkbox"/> Lower Leg or <input type="checkbox"/> Knee (729.5)
___	___	Pain in <input type="checkbox"/> Ankle or <input type="checkbox"/> Foot (719.47)
___	___	Jaw Pain (526.9)
___	___	Joint <input type="checkbox"/> Swelling (719.0) / <input type="checkbox"/> 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 <input type="checkbox"/> Soreness / <input type="checkbox"/> 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)
___	___	<input type="checkbox"/> Constipation / <input type="checkbox"/> Irregular Bowel Habits (564.0)
___	___	Difficulty Swallowing (787.2)
___	___	<input type="checkbox"/> Heartburn / <input type="checkbox"/> Indigestion (787.1)
___	___	<input type="checkbox"/> Dermatitis / <input type="checkbox"/> Eczema / <input type="checkbox"/> Rash (692.9)
___	___	Depression (311.9)

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 <input type="checkbox"/> Past (v10) <input type="checkbox"/> 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 <input type="checkbox"/> Type I (250.01) <input type="checkbox"/> Type II (250.00)
___	___	Epilepsy (349.5)
___	___	Ulcer (556.9)
___	___	<input type="checkbox"/> Liver (573.9) / <input type="checkbox"/> Gallbladder Problems (575.9)
___	___	Kidney Stones (592.0)
___	___	Hepatitis (573.3)
___	___	Bladder Infection (595.9)
___	___	Kidney Disorders (v11.03)
___	___	Colitis (558.9)
___	___	Abnormal Weight <input type="checkbox"/> Gain (783.1) / <input type="checkbox"/> Loss (783.2)
___	___	HIV (v08) / AIDS (042)
___	___	Anorexia (307.1)
___	___	Systemic Lupus (710.0)
___	___	Other _____

Yes	No	Tobacco <input type="checkbox"/> Present (305.1) <input type="checkbox"/> Past (v15.82)
___	___	Alcohol If Yes, Frequency: _____
___	___	<input type="checkbox"/> Drug / <input type="checkbox"/> Alcohol Dependence (v11.3/303.99)
___	___	<input type="checkbox"/> Coffee / <input type="checkbox"/> Tea / <input type="checkbox"/> Caffeinated Soft Drinks
___	___	Servings per Day: _____
___	___	Hospitalization / Surgeries: _____
___	___	Prior Accidents/Injuries: _____
___	___	Current Medications (Rx, OTC, Vitamins): _____

Yes No

___ ___ Do You Have A Permanent Disability Rating?

Area of the Body Affected: _____

Date Rating Received: _____

Rating Percentage: _____

Please List Any Known Allergies: _____

Weight _____ lbs **Height** _____ Ft _____ In

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)	_____

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

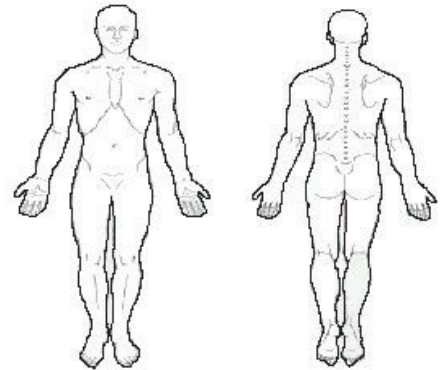
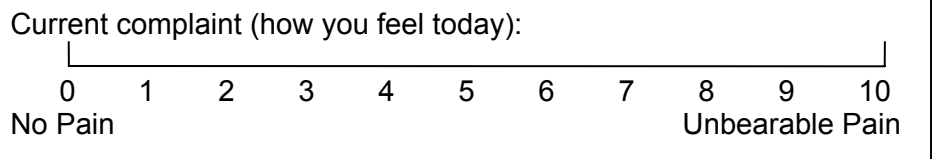
Patient Name: _____ Birthdate: _____ Sex: M/F
Address: _____ City: _____ State: _____ Zip: _____
Telephone _____ Social Security #: _____ Driver Lic. #: _____
Occupation: _____ Employer: _____ Work Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Subscriber Name: _____ Health Plan: _____
Subscriber ID #: _____ Group #: _____ Spouse Name: _____
Spouse Employer: _____ City: _____ State: _____ Zip: _____
Primary Care Physician Name: _____ PCP Phone: _____

MARK AN X ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS.

DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

Is this? Work Related Auto Related N/A

DATE PROBLEM BEGAN: _____



How often are your symptoms present? 0-25% 26-50% 51-75% 76-100%
Can you perform your daily activities? Yes No (Describe) _____

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? No Yes **Date(s) taken:** _____

WHAT AREAS WERE TAKEN? _____

Please check all of the following that apply to you: None Apply

No	Yes	Condition	No	Yes	Condition
<input type="checkbox"/>	<input type="checkbox"/>	History of Recent Infection	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Recent Fever	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy, # of births _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight <input type="checkbox"/> Gain <input type="checkbox"/> Loss
<input type="checkbox"/>	<input type="checkbox"/>	Corticosteroid Use	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills	<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	History of Low/Mid Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (date) _____	<input type="checkbox"/>	<input type="checkbox"/>	History of Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Numbness in Groin/Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	History of Alcohol Use
<input type="checkbox"/>	<input type="checkbox"/>	Urinary Retention	<input type="checkbox"/>	<input type="checkbox"/>	History of Tobacco Use
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries/Medications: _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor			_____
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis			_____
<input type="checkbox"/>	<input type="checkbox"/>	Recent Trauma			_____

Family History: Cancer Diabetes High Blood Pressure Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor or a clinical peer employed by ASH Networks may need to contact my physician if my condition needs to be co-managed. Therefore I give authorization to my chiropractor and/or ASH Networks to contact my physician, if necessary.

Patient Signature: _____ **Date:** _____