

PATIENT REGISTRATION TO SAVE TIME YOU MAY FAX THIS FORM TO US AT (866) 526-3554

NAME _____ DATE _____

ADDRESS _____ APT. _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____ SOC. SEC. NO. _____ DATE OF BIRTH _____

MARITAL STATUS _____ SEX _____ AGE _____ NUMBER OF CHILDREN _____

OCCUPATION _____ EMPLOYER _____

NAME OF SPOUSE _____ SPOUSE'S OCCUPATION _____

NEAREST RELATIVE (Not living with you) _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

REFERRED BY _____ YELLOW PAGES _____ FRIEND _____ WEB _____

DR. _____ NEWSLETTER _____

WERE YOU HURT: AT WORK _____ AUTO ACCIDENT _____ OTHER _____

WHAT MEDICATIONS ARE YOU TAKING? _____

FAMILY HISTORY OF: HEART DISEASE _____ CANCER _____ DIABETES _____ ARTHRITIS _____

INSURANCE COMPANY _____ MEMBER ID# _____

WE CAN ALSO HELP YOU WITH: check all that apply

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Gastro Intestinal Health | <input type="checkbox"/> Low Energy | <input type="checkbox"/> PMS/Menstrual Cycle Issues | <input type="checkbox"/> Immune System Support |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Sleep Support | <input type="checkbox"/> Blood Sugar Control | <input type="checkbox"/> Detoxification |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Stress | <input type="checkbox"/> Women's Health Issues | <input type="checkbox"/> Men's Health Issues |

MAJOR PAIN OR PROBLEM TODAY _____

HOW DID IT HAPPEN? _____

ARE YOU PREGNANT ? _____ WHEN WERE YOU LAST X-RAYED _____ BY WHOM _____

Check symptoms you have noticed: Use N if problem Now Use P if problem in the Past Leave blank if OK

- | | | |
|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in shoulder | <input type="checkbox"/> Low back pains |
| <input type="checkbox"/> Head feels heavy | <input type="checkbox"/> Muscle spasm in shoulder | <input type="checkbox"/> Low back muscle spasm |
| <input type="checkbox"/> Light headed | <input type="checkbox"/> Pain in neck | <input type="checkbox"/> Pain into buttock |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Pain into thigh |
| <input type="checkbox"/> Dizzy | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Pain down leg |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Pain in arm and hand | <input type="checkbox"/> Pain in ankle |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Pins and needles in arms/hands | <input type="checkbox"/> Pain in foot |
| <input type="checkbox"/> Loss of hearing | <input type="checkbox"/> Loss of grip strength | <input type="checkbox"/> Pain in knee |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Pain in elbow |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Pain in wrist |

TODAYS PAIN OR PROBLEM STARTED WHEN _____

PAINS ARE: SHARP _____ DULL _____ CONSTANT _____ INTERMITTENT _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE? _____

OTHER DOCTORS SEEN FOR THIS CONDITION _____

ANY HOME REMEDIES _____

PREVIOUS SERIOUS ILLNESS:(Please list & describe) CANCER _____ FRACTURES _____

If you are accepted as a patient you are expected to pay at the end of each visit unless other arrangements are approved

Date _____ Patient/Parent Signature _____

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to the office below, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid

Date _____ Patient's Signature _____

AUTO AND OTHER ACCIDENTS - NOTICE OF LIEN TO ATTORNEY

I hereby authorize and direct you, my attorney, to pay directly to said doctor such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a Lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney, or myself, as the result of the injuries for which I have been treated or injuries in connection therewith.

I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were executed by him I have received a copy of this document

Date _____ Patient's Signature _____

The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment, or verdict, as may be necessary to adequately protect said doctor above named. Attorney further agrees that in the event this lien is litigated that the prevailing party will be awarded attorney fees and costs.

Date _____ Attorney's Signature _____