Bonsall Chiropractic Registration and History

1 Patient Information

Date: _____

Patient: _____

Address: _____

_____
City State Zip

Sex: M ☐ F ☐ Age: _____ Birthdate: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#: _____

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone: _____

Spouse's Name: _____

Birthdate: _____ SS#: _____

Occupation: _____

Spouse's Employer: _____

Whom may we thank for referring you? _____

_____

2 Insurance

Who is responsible for this account?: _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

Is patient covered by additional insurance?

Subscriber's Name: _____

Birthdate: _____

Relationship to Patient: _____

Insurance Co.: _____

Group #: _____

ASSIGNMENT AND RELEASE

I the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship Date

3 Phone Numbers

Home: _____ Work: _____ Cell: _____

Best time and place to reach you: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____ Relationship: _____

Home: _____ Work: _____ Cell: _____

4 Accident Information

Is condition due to an accident? ☐ Yes ☐ No Date: _____

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?

☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable): _____

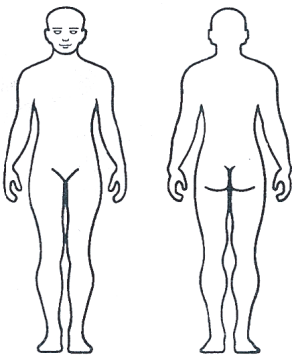
5 Patient Condition

Reason for Visit: _____

When did your symptoms appear?: _____

Is this condition getting progressively worse?: ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling. →



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain): _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain?: _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movement that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down