

CHIROPRACTIC REGISTRATION

PATIENT INFORMATION

Date _____

Patient _____
Last First Middle Initial

Address _____
City State Zip

Patient SSN _____

Sex: M F Age _____ Birthdate _____

Single Married Widowed Separated Divorced

Occupation _____

Employer _____

Employer's Address _____
City State Zip

Guardian's information, if a minor/Spouse's information, if married

Name _____

Birthdate _____ SSN _____

Occupation _____

Employer _____

How did you hear about our office? _____

INSURANCE

Primary Insurance Co. _____

Ins. Co. Phone # _____

Policyholder's Name _____

Sex: M F Age _____ Birthdate _____

ID/Contract/Claim # _____

Group/Policy # _____

Secondary Insurance Co. _____

Ins. Co. Phone # _____

Policyholder's Name _____

Sex: M F Age _____ Birthdate _____

ID/Contract/Claim # _____

Group/Policy # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the above stated companies and assign directly to **Dr. Paul H. Gurney** all insurance benefits, if any, otherwise payable to me for services rendered. I authorize this office to make a complaint with the insurance commissioner on my behalf. I understand that I am financially responsible 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.

 Policyholder's signature Date

CONTACT INFORMATION

Home # _____ E-mail _____

Cell # _____ Work # _____ Ext _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home/cell # _____ Work # _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date _____

Type of accident Auto Work Sport Other

Location of accident _____

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

PATIENT CONDITION

Describe your current symptoms: _____

When your symptoms began: _____

How your symptoms began: _____

Activities that are painful to perform Sitting Standing Walking Bending Lying Down

Lifting Resting Looking Down Other _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning

Tingling Cramps Stiffness Swelling Other _____

Is your condition getting Better Worse Same?

How bad is your pain now? 0 1 2 3 4 5 6 7 8 9 10
No Pain Unbearable Pain

How often do you have pain? 0--10--20--30--40--50--60--70--80--90--100 (% of day)

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

