

Sunland Chiropractic Center Patient Registration

Patient Information

Name:			Home Phone:			Cell / Mobile Phone:			
Address:				City:			State:		Zip:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		Birth date:		Age:	# Of Children:		S/S#	
Occupation:		Employed by:		Work Address:			Work Phone Number:		
Spouses name (Or Parent):			Spouses (Or Parent) Employer:			Who may we thank for referring you to our office?			
Have you ever had Chiropractic Care before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?			Would you like to receive our monthly newsletter by email? <input type="checkbox"/> Yes <input type="checkbox"/> No			Your email address is:			

List your chief complaints in order of severity:

1. _____ For how long? _____

2. _____ For how long? _____

3. _____ For how long? _____

How did this condition or injury happen? _____

Is this injury or illness work related? Yes No Have you reported it to your employer? Yes No Date of injury: _____

Is this injury due to an automobile accident? Yes No (If yes, please give us your information:)

Auto Insurance Co. _____ Policy#: _____ Claim #: _____

Agents Name: _____ Address: _____ Phone: _____

Do you have any type of health insurance? Yes No *If yes, please provide us with the following information:*

Insurance Company Name: _____ Policy Number: _____

Name of the primary insured on the policy: _____ Your relation: _____

Are you covered under any other group or individual health policy through yourself or spouse? (i.e.: secondary or supplemental policy) Yes No

If yes, Insurance Company Name: _____ Employer: _____

Spouses Social Security Number: _____ Spouses date of birth: _____ Policy #: _____

Have you seen another doctor for this condition? No Yes (If Yes, Please give Dr.'s name) _____

What medications are you currently taking? _____

Please list any surgical operations you have had: _____

Do you have a pacemaker? Yes No

Have you or any of your family members had any of the following conditions? Check off all that apply

- | | | | | | |
|-----------------------------------|------------------------------------|--|------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive disorders | <input type="checkbox"/> Headaches | <input type="checkbox"/> Backaches | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Immune disorders | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> other |

Assignment And Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Roderick L. Chapman, D.C. all insurance benefits, if any, otherwise payable to me for services rendered. 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 claim submissions.

Responsible Party's Signature _____ **Relationship to patient** _____ **Date** _____

