Registration Form

Patient Information

Patient Name:_____ DOB:_____

SSN:_____ Sex (circle one): MALE FEMALE

Marital Status (circle one):

SINGLE MARRIED DIVORCED SEPERATED WIDOWED PARTNER

Is patient a minor? YES NO
If yes, who is legal guardian/parent responsible for patient?

_____Phone #:_____

Contact Information

Address:_____Apt._____

City:_____ State:_____ Zip:_____

Home #: _____Cell #: _____

Work #:_____E-mail:_____

Occupation: _____Employer:_____

Spouse's Name:_____

How did you hear about our office:_____

Insurance Information- Please have front desk copy your insurance card.

Insurance Carrier Name:_____ Phone #:_____

Policy#: _____Group#:_____

Address:_____

~OVER~

Accident Information

Type of Accident (circle one):

AUTO WORK-RELATED HOME OTHER:_____

Have you reported this accident: YES NO

If yes, to whom:_____

~If Automobile accident, please complete Personal Injury Questionnaire~

If work-related, complete the following:

Employer:_____ Date of Injury:_____

Claim # (if claim is opened):_____

Injuries/ Surgeries

Have you ever sustained a fall or an injury that required medical attention: YES NO

~Please complete the following with approximate dates and a brief description~

Falls/ Head Injuries:_____

Broken Bones/ Dislocations:_____

Surgeries:_____

Work Injuries:_____

Auto Accidents:_____

Medications

Medications:_____

Allergies:_____

Vitamins/Herbs/ Supplements:_____

Health History

What treatment have you already received for this condition:

_____

Name of Doctor(s) who have already treated you for this condition:

_____

Date of last Physical Exam:_____

Date of last Spinal Adjustment: _____

Date of last X-Ray/ MRI:_____

Please circle all that apply

AIDS/ HIV	**Heart Disease**	**Rheumatic Fever**
Alcoholism	**Hepatitis**	**Scarlet Fever**
Allergy Shots	**Hernia**	**Sinus Infections**
Anemia	**Herniated Disc**	**STD's**
Anorexia/Bulimia	**Herpes**	**Stroke**
Appendicitis	**High Blood Pressure**	**Thyroid Problems**
Arthritis	**High Cholesterol**	**Tonsillitis**
Asthma	**Infertility**	**Tuberculosis**
Bleeding Disorder	**Kidney Disease**	**Tumors-Growths**
Bronchitis	**Liver Disease**	**Typhoid Fever**
Cancer	**Measles**	**Ulcers**
Cataracts	**Migraines**	**Vision Problems**
Chemical Dependency	**Mononucleosis**	**Vaginal Infections**
Chicken Pox	**Multiple Sclerosis**	**Venereal Disease**
Diabetes	**Mumps**	**Whooping Cough**
Dizziness	**Osteoporosis**	**Other:_____**
Emphysema	**Pacemaker**	**_____**
Epilepsy	**Parkinson's**	
Disease	**_____**	
Fatigue	**Pinched Nerve**	
Fractures	**Pneumonia**	
Glaucoma	**Polio**	
Goiter	**Prostate Problem**	
Gout	**Prosthesis**	
Headaches	**Psychiatric Care**	
Hearing Loss	**Rheumatoid Arthritis**	

~OVER~

Personal Lifestyle (Please Circle)

Exercise	Work Activity	Habits
None Moderate Daily Heavy	Sitting Standing Light Labor Heavy Labor	Smoking Packs/Day_____ Alcohol Drinks/Wk_____ Coffee/Caffeine Drinks Cups/Day_____ High Stress Level_____

Payment Options

_____ Health Insurance: Benefits are based upon the contract set up by your insurance carrier. Co-pays are due at time of service.

_____ No Insurance: Payment expected at time of service.

_____ Medicare: Chiropractic exams and x-rays are not covered by Medicare. Medicare will pay approximately 80% of your treatments. Payments for these services are required at the time of your initial visit.

_____ Personal Injury (Car Accident): We will need to obtain the correct billing information for your claim. We do not bill 3rd party insurance. If it is a 3rd party case, we will expect payment at time of service.

_____ Work Related: You are filing a claim with the Dept. of Labor and Industries or a self-insured agency, through your employer. If the claim is accepted you will not receive copies of your billings or statements. If your claim is denied, your account with our office immediately becomes your responsibility and you will pay for all services rendered in our office.

Assignment

I, the undersigned, certify that I (or my dependant) have insurance with_____ and I authorize direct payment to Gauthun Chiropractic for any insurance benefits otherwise payable to me for the services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I authorize the release of my information to secure benefits. I authorize the use of this signature on all insurance claims. I understand that a copy of my insurance card will be kept on file for the purpose of billing all charges rendered herein. The above information is true and correct to the best of my knowledge. I accept and acknowledge ultimate responsibility for all charges incurred. All fees are payable at time of service, unless other arrangements are made in advance.

_____ _____

Patient/ Guardian Signature Date