PATIENT REGISTRATION FORM

NAME	HOME #
ADDRESS	WORK #
CITY-STATE-ZIP	FAX #

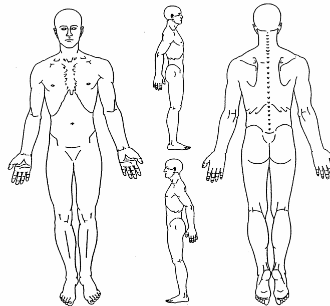
EMERGENCY CONTACT	PHONE #	SS #	E-MAIL

O MALE O FEMALE	O S O M O D O W	DATE OF BIRTH	DRIVER LICENSE #

EMPLOYER	OCCUPATION
ADDRESS	CITY-STATE-ZIP
REFERRED BY	PRIVATE PHYSICIAN

PLEASE INDICATE REGION OF COMPLAINT

O HEADACHE PAIN
O NECK PAIN
O UPPER/MID BACK PAIN
O LOW BACK PAIN
O SHOULDER-ELBOW-WRIST-HAND PAIN
O HIP-KNEE-ANKLE-FOOT PAIN
O OTHER



USE THE LETTERS LISTED BELOW TO INDICATE THE *TYPE* AND *LOCATION* OF YOUR PAIN AND SENSATIONS...

KEY
A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES

MEDICAL HISTORY

	YES	NO	
▪ ARTHRITIC CONDITION	O	O	▪ LIST MEDICATIONS
▪ CANCER	O	O	-
▪ DIABETES	O	O	-
▪ HEART PROBLEMS	O	O	-
▪ HIGH BLOOD PRESSURE	O	O	▪ ALLERGIC TO MEDICATIONS
▪ VASCULAR CONDITION	O	O	-
▪ LUNG PROBLEMS	O	O	-
▪ USUAL CHILDHOOD DISEASES	O	O	▪ ALLERGIES
▪ UNUSUAL CHILDHOOD DISEASES	O	O	-
▪ CURRENTLY PREGNANT	O	O	-
▪ EXERCISE REGULARLY	O	O	▪ HEIGHT
▪ SMOKER	O	O	▪ WEIGHT
▪ ALCOHOL	O	O	▪ LIST SURGERIES / HOSPITALIZATIONS
▪ ALLERGIES	O	O	-
▪ BIRTH CONTROL MEDICATIONS	O	O	-
▪ OTHER			

SPECIFIC INJURY? O YES O NO	DATE OF INJURY
PREVIOUS TREATMENT? O YES O NO	TREATMENT TYPE
DOCTOR NAME	PHONE #

NATURE OF INJURY		
	O AUTO	COMPLETE SECTIONS 1 & 3 ONLY
	O WORK RELATED	COMPLETE SECTIONS 2 & 3 ONLY
	O HOME / OTHER	COMPLETE SECTION 3 ONLY

SECTION #1 – PERSONAL INJURY

DATE	TIME O AM O PM		LOCATION OF ACCIDENT
O AUTO V AUTO	O AUTO V TRUCK	O MOTORCYCLE	O AUTO V BUS
O AUTO V PEDESTRIAN	O SLIP & FALL	O OTHER	
PLEASE DESCRIBE INJURY			
O DRIVER OR O PASSENGER	O FRONT SEAT OR O BACK SEAT	WEARING SEAT BELT OR SHOULDER HARNESS?	O YES O NO
BODY PARTS STRUCK	O YES O NO	IF YES, PLEASE LIST	
EMERGENCY TREATMENT?	O YES O NO	IF YES, WHERE?	
WORK – RELATED?	O YES O NO	IF YES, ANY WORK LOSS?	O YES O NO
LOSS OF CONSCIOUSNESS?	O YES O NO	WERE YOU BLEEDING?	O YES O NO
X – RAY TAKEN?	O YES O NO	IF YES, LIST AREAS	

SECTION #2 – WORKERS' COMPENSATION INJURY / EMPLOYER INFORMATION

COMPANY NAME		
ADDRESS		
CITY-STATE-ZIP		
TYPE OF BUSINESS		
OCCUPATION		
DATE OF INJURY	TIME OF INJURY O AM / O PM	DATE LAST WORKED
DESCRIBE INJURY		
INJURED AT [LOCATION-STREET-CITY-STATE-ZIP]		

SECTION #3 – INSURANCE INFORMATION / METHOD OF PAYMENT

O CASH O CHECK O CREDIT CARD	O GENERAL HEALTH INSURANCE	O WORKERS' COMPENSATION INSURANCE	O AUTO INSURANCE
INSURANCE COMPANY		CLAIM REPRESENTATIVE	
POLICY #	GROUP #	CLAIM #	
ADDRESS			
CITY-STATE-ZIP		PHONE #	
NAME OF INSURED		SS #	O SELF O OTHER
AUTO MED – PAY INSURANCE COMPANY		POLICY #	

AUTHORIZATION TO RELEASE MEDICAL INFORMATION / FINANCIAL AGREEMENT

I HEREBY AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION REQUESTED BY MY INSURANCE COMPANY TO DOCUMENT MY CLAIM FOR BENEFITS. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF ALL CHARGES FOR MY TREATMENT. SERVICES ARE PAYABLE AT THE TIME RENDERED.

PATIENT OR GUARDIAN SIGNATURE

DATE