

CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Patient's Full Name: _____ Today's Date: _____

Street: _____ Apt No.: _____

City: _____ State: _____ ZIP: _____

Birth date: ____/____/____ Age: _____ Sex: **Male** **Female**

Social Security#: _____

Marital Status: **Single** **Married** **Widowed** **Separated** **Divorced**

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E Mail: _____

Best time and place to reach you: _____

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Spouse's Name: _____

Occupation: _____ Employer: _____

In Case Of Emergency, Contact: _____

Relationship: _____ Home Phone: _____ Cell or Work Phone: _____

PAYMENT INFORMATION

Who is responsible for this account? _____ Relationship to patient? _____

_____ I **do not have insurance coverage** for Chiropractic Care with Dr. Parmiter and I understand I am fully responsible for all charges and that payment is due when services are rendered, unless other payment arrangements have been established. I also understand a 5% interest charge may be charged per month on any outstanding balance. I agree to be responsible for court costs and an additional 33 1/3% of balance for attorney fees associated with the collections procedures brought by Health Links, Inc., should that be necessary. Any returned checks will be subject to a \$25.00 service charge.

Signature _____ Date: _____

_____ I, the undersigned, certify that I (or my dependent) **have insurance coverage** with the carrier listed below. I assign directly to **Dr. Jon K. Parmiter** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am fully responsible for all charges whether or not paid by insurance and that copayments or costshares are due at the time service is rendered, unless other arrangements have been established.** I also understand a 5% interest charge may be charged per month on any outstanding balance. I agree to be responsible for court costs and an additional 33 1/3% of balance for attorney fees associated with the collections procedures brought by Health Links, Inc., should that be necessary. Any returned checks will be subject to a \$25.00 service charge.

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.

Signature: _____ Date: _____

Insurance Carrier: _____ Member# _____ Group#: _____

Subscriber: _____ Subscriber DOB: _____

Are you aware of the Chiropractic Benefits your policy offers? YES NO

Please complete next page

Patient name: _____ Date: _____

ACCIDENT INFORMATION

Is condition due to an accident? **NO** **YES** Type of accident? **AUTO** **WORK** **HOME** **OTHER** _____
To whom have you made a report of your accident? **AUTO INSURANCE** **EMPLOYER** **WORKER COMP** **OTHER** _____
Auto Insurance Company _____ Agent/Phone _____

Claim #: _____

Attorney Name/phone (if applicable): _____

PATIENT CONDITION

Reason for Visit _____

When did symptoms appear? _____

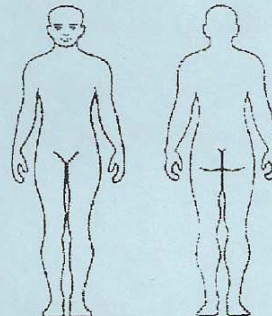
Is this condition getting progressively worse? **YES** **NO** **UNKNOWN**

How often do you have this pain? _____

Is it constant or does it come and go? _____

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: (circle all that apply) **SHARP** **DULL** **THROBING** **NUMBNESS** **ACHING**
SHOOTING **BURNING** **TINGLING** **CRAMPS** **STIFFNESS** **SWELLING** **OTHER** _____

Does it interfere with your: **WORK** **SLEEP** **DAILY ROUTINE** **RECREATION**

Activities or movements that are painful to perform: **SITTING** **STANDING** **WALKING** **BENDING** **LYING DOWN**

HEALTH HISTORY

What treatment have you received for your condition? _____

Name of your Primary Care Physician _____ date last seen? _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | | | | | | | | |
|---------------|----------------|----------------|----------------|----------------|----------------|------------------|----------------|-----------------|----------------|
| AIDS/HIV | __yes__ __no__ | Chemical | | Herpes | __yes__ __no__ | Parkinson's | | Suicide Attempt | __yes__ __no__ |
| Alcoholism | __yes__ __no__ | Dependency | __yes__ __no__ | High | | Disease | __yes__ __no__ | Thyroid | |
| Allergy Shots | __yes__ __no__ | Chicken Pox | __yes__ __no__ | Cholesterol | __yes__ __no__ | Pinched Nerve | __yes__ __no__ | Problems | __yes__ __no__ |
| Anemia | __yes__ __no__ | Diabetes | __yes__ __no__ | Kidney Disease | __yes__ __no__ | Pneumonia | __yes__ __no__ | Tonsillitis | __yes__ __no__ |
| Anorexia | __yes__ __no__ | Emphysema | __yes__ __no__ | Liver Disease | __yes__ __no__ | Polio | __yes__ __no__ | Tuberculosis | __yes__ __no__ |
| Appendicitis | __yes__ __no__ | Epilepsy | __yes__ __no__ | Measles | __yes__ __no__ | Prostate | | Tumors, | |
| Arthritis | __yes__ __no__ | Fractures | __yes__ __no__ | Migraine | | Problems | __yes__ __no__ | Growths | __yes__ __no__ |
| Asthma | __yes__ __no__ | Glaucoma | __yes__ __no__ | Headaches | __yes__ __no__ | Prosthesis | __yes__ __no__ | Typhoid Fever | __yes__ __no__ |
| Bleeding | | Goiter | __yes__ __no__ | Miscarriage | __yes__ __no__ | Psychiatric Care | __yes__ __no__ | Ulcers | __yes__ __no__ |
| Disorders | __yes__ __no__ | Gonorrhea | __yes__ __no__ | Mononucleosis | __yes__ __no__ | Rheumatoid | | Vaginal | |
| Breast Lump | __yes__ __no__ | Gout | __yes__ __no__ | Multiple | | Arthritis | __yes__ __no__ | Infections | __yes__ __no__ |
| Bronchitis | __yes__ __no__ | Heart Disease | __yes__ __no__ | Sclerosis | __yes__ __no__ | Rheumatic | | Venereal | |
| Bulimia | __yes__ __no__ | Hepatitis | __yes__ __no__ | Mumps | __yes__ __no__ | Fever | __yes__ __no__ | Disease | __yes__ __no__ |
| Cancer | __yes__ __no__ | Hernia | __yes__ __no__ | Osteoporosis | __yes__ __no__ | Scarlet Fever | __yes__ __no__ | Whooping | |
| Cataracts | __yes__ __no__ | Herniated Disk | __yes__ __no__ | Pacemaker | __yes__ __no__ | Stroke | __yes__ __no__ | Cough | __yes__ __no__ |

Other _____

Exercise: **NONE** **MODERATE** **DAILY** **HEAVY**

Work Activity: **SITTING** **STANDING** **LIGHT LABOR** **HEAVY LABOR**

Habits: **SMOKING** (____ PACKS/DAY) **ALCOHOL**(____ DRINKS/WEEK) **CAFFEINE**(____ CUPS/DAY)

HIGH STRESS(REASON _____)

Are you Pregnant? **YES** **NO** Due Date? _____

Injuries you have had and date? _____

Medications/Vitamins you are taking? _____