CHIROPRACTIC REGISTRATION AND HISTORY

PATIENT INFORMATION

Date ____________

Patient ____________

Address ____________

____
City State Zip

Sex: ☐ M ☐ F Age ______ Birthdate ____________

Single Married Widowed Separated Divorced

Patient SS# ____________

Email ____________

Occupation ____________

Employer ____________

Employer Address ____________

Employer Phone ____________

Spouse's Name ____________

Birthdate ____________ SS# ____________

Occupation ____________

Spouse's Employer ____________

Whom may we thank for referring you? ____________

INSURANCE

Who is responsible for this account? ____________

Relationship to Patient ____________

Insurance Co. ____________

Group # ____________

Is patient covered by additional insurance? Yes No

Subscriber's Name ____________

Birthdate ____________ SS# ____________

Relationship to patient ____________

Insurance Co. ____________

Group # ____________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with____________and assign directly to Dr. Allen Knecht 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 submissions.

____
Responsible Party Signature

____________ ____________
Relationship Date

PHONE NUMBERS

Home ____________ Work ____________Ext ______

Cell ____________ Other ____________

IN CASE OF EMERGENCY, CONTACT

Name ____________Relationship ____________

Home Phone ____________ Cell Phone ____________

ACCIDENT INFORMATION

Is condition due to an accident? Yes No Date ______

Type of accident: Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) ____________

PATIENT INFORMATION

Reason for Visit ____________

When did your symptoms appear? ____________

Is this condition getting progressively worse? ____________

Where do 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: Sharp Dull Throbbing Numbness Aching Swelling
Burning Tingling Cramps Stiffness Swelling Other ____________

How often do you have this pain? ____________

Is it constant or does it come and go? ____________

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform: Sitting Standing Walking Bending Lying down