CHIROPRACTIC REGISTRATION AND HISTORY

(1) PATIENT INFORMATION

DATE ______________

Legal Name ________________________________
First M. Int. Last

Address ________________________________

City ________________________________

State ______________ Zip ______________

Home Phone ________________________________

Cell/Work ________________________________

Email ________________________________

Sex: ☐ Male ☐ Female

Marital Status
☐ Married ☐ Widowed ☐ Single

☐ Separtated ☐ Divorced ☐ Unknown

Birthdate ________________________________

SS# ______________________

Work Status ☐ Employed ☐ Full Time Student ☐ Other

Apt Reminder ☐ Email ☐ Text

Whom may we thank for referring you? ______________

(2) Emergency Contact

Name: ________________________________

Phone: ________________________________

Email: ________________________________

(3) INSURANCE INFORMATION

(PLEASE PRESENT CARD)

Insurance Co. ________________________________

Members# ______________ Group # ______________

Subscribers Name ________________________________

Birth date ______________ SS# ______________

Relationship to Patient ________________________________

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent (s), have insurance coverage and assign directly to Johnson Ferry Chiropractic Center. 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 authorize the use of my signature on all insurance submissions.

JFCC doctors may use health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent,

(4). ACCIDENT INFORMATION

Is condition due to accident? ☐ Yes ☐ No

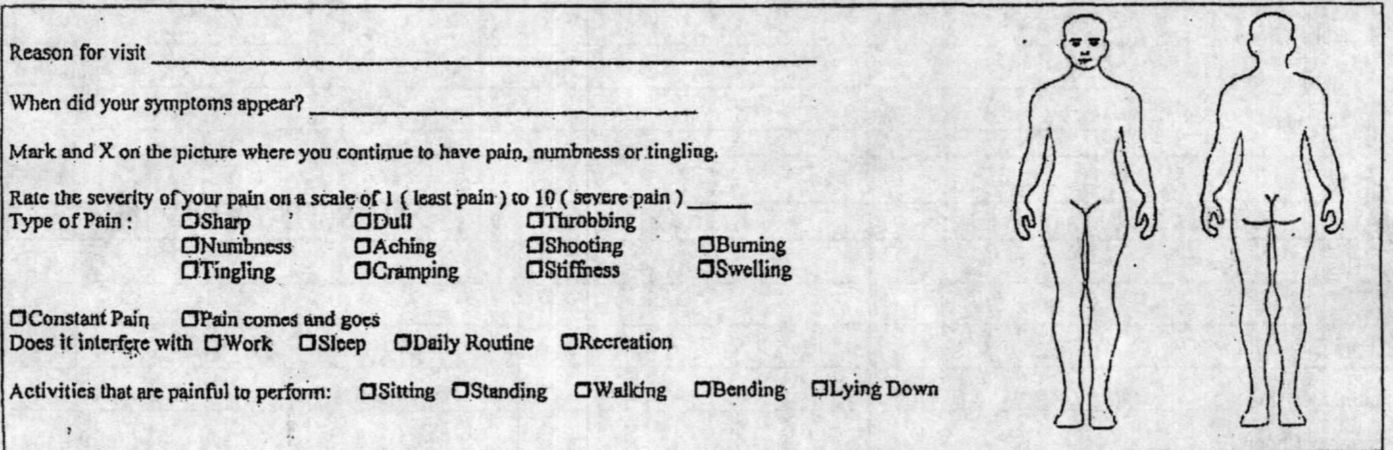
Date of accident ______________

Type of accident ☐ Auto ☐ Work ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable) ______________

(5) PATIENT CONDITION



Reason for visit ________________________________

When did your symptoms appear? ______________

Mark and X on the picture where you contimue to have pain, numbness or tingling.

Rate the severity of your pain on a scale of 1 (least pain) to 10 (severe pain) _____

Type of Pain : ☐ Sharp ☐ Dull ☐ Throbbing
☐ Numbness ☐ Aching ☐ Shooting ☐ Burning
☐ Tingling ☐ Cramping ☐ Stiffness ☐ Swelling

☐ Constant Pain ☐ Pain comes and goes

Does it interfere with ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down