Welcome

Registration Form

PATIENT INFORMATION

Last Name, First Name MI ______ Title ______ Preferred Name ______

Date of Birth ______ Age ______ Gender ______ Marital Status ______ Spouse/Parent Name ______

Street Address ______ City ______ State ______ Zip ______

Mailing Address (if different) ______ City ______ State ______ Zip ______

SSN ______ Home Number ______ Cell Number ______ Work Number ______

Email (for private use by this office only) ______ Employer ______ Occupation ______

Whom may we thank for referring us to you? ______ Other family members seen here ______

EMERGENCY CONTACT

Name of local friend or relative (not living with you) ______ Home Phone ______ Cell Phone ______

INSURANCE INFORMATION

Person responsible for bill ______ Is this person a patient here? ______

Primary subscriber name ______ Date of birth ______

Primary Insurance ______ Phone ______ ID/SSN # of subscriber ______ Group # ______

Secondary subscriber name ______ Date of birth ______

Secondary Insurance ______ Phone ______ ID/SSN of subscriber ______ Group # ______

BACK AND BODY
CHIROPRACTIC

HEALTH HISTORY

SYMPTONS

	List your problems or complaints according to severity of pain	Rate Your Pain 0-10 (10=worst)	Date started or for how long	If you've had this condition before, when?	Did your problem begin with an injury
1					
2					
3					
4					
5					
6					

Please answer the following in regards to problem/complain #1 above:

How would you describe the pain? € Sharp € Dull € Diffuse€ Achy € Burning € Shooting € Stiff € Numb
€ Tingly € Sharp w/motion € shooting w/motion € Stabbing w/motion € Electric like w/motion

Is the problem? € Getting worse € Staying the same € Getting better

How often do you experience your symptoms? € Constantly (76-100%) € Frequently (51-76%) € Occasionally (26-50%) € Intermittently (1-25%)

How much has the problem interfered with your normal activities? € Not at all € A little bit € Moderately € Quite a bit € Extremely

How much has the problem interfered with your work/required tasks? € Not at all € A little bit € Moderately € Quite a bit € Extremely € Do not work

Do you consider your problem to be severe? € Yes € Yes, at times € No

What aggravates your problem? ____________________

What makes your problem feel better? ____________________

What concerns you the most about your problem; what does it prevent you from doing? ____________________

Who else have you seen for your problem? € Chiropractor € Neurologist € Primary Care Physician € No one € ER Physician € Orthopedist € Massage Therapist € Physical Therapist € Other: ____________________

Name and city of your primary care physician and/or specialist: ____________________

How would you rate your overall health? € Excellent € Very good € Good € Fair € Poor

What type of exercise do you do? € Strenuous € Moderate € Light € None

Past	Present	
€	€	Headaches
€	€	Neck Pain
€	€	Upper Back Pain
€	€	Mid Back Pain
€	€	Low Back Pain
€	€	Shoulder Pain
€	€	Elbow/Upper Arm Pain
€	€	Wrist Pain
€	€	Hand Pain
€	€	Hip Pain
€	€	Upper Leg Pain
€	€	Knee Pain
€	€	Ankle/Foot Pain
€	€	Jaw Pain
€	€	Joint Pain/Stiffness
€	€	Arthritis
€	€	Rheumatoid Arthritis
€	€	Cancer
€	€	Tumor
€	€	Asthma

Past	Present	
€	€	Chronic Sinusitis
€	€	High Blood Pressure
€	€	Chest Pain
€	€	Stroke
€	€	Angina
€	€	Kidney Stone
€	€	Kidney Disorder
€	€	Bladder Infection
€	€	Painful Urination
€	€	Loss of Bladder Control
€	€	Prostate Problems
€	€	Abnormal Weight Change
€	€	Loss of Appetite
€	€	Abdominal Pain
€	€	Ulcer
€	€	Hepatitis
€	€	Liver/Gall Bladder Disorder
€	€	General Fatigue
€	€	Muscular Incoordination
€	€	Visual Disturbances

Past	Present	
€	€	Dizziness
€	€	Diabetes
€	€	Excessive Thirst
€	€	Frequent Urination
€	€	Smoking/Tobacco Use
€	€	Allergies
€	€	Depression
€	€	Systemic Lupus
€	€	Epilepsy
€	€	Dermatitis/Eczema
€	€	HIV/AIDS
€	€	Other: ____________________

____

____

____

For Females Only

€	€	Birth Control Pills
€	€	Hormonal Replacement
€	€	Pregnancy

List all the prescription medications you are currently taking: ____________________

____

____

List all the vitamins/supplements you are currently taking: ____________________

____

List all the surgical procedures you have had: ____________________

What activities do you do at work?

€ **Sit:**	€ Most of the day	€ Half the day	€ A little of the day
€ **Stand:**	€ Most of the day	€ Half the day	€ A little of the day
€ **Computer Work:**	€ Most of the day	€ Half the day	€ A little of the day
€ **On the Phone:**	€ Most of the day	€ Half the day	€ A little of the day

What activities do you do outside of work? ____________________

Have you had any significant past trauma? ____________________

Anything else we should know? ____________________

____

CONSENT TO TREAT A MINOR

(If applicable)

Back & Body Chiropractic has my permission to render any medically necessary services to my child

Printed Name of PATIENT	Signature of PARENT/GUARDIAN	Date

CERTIFICATION

To the best of my knowledge, the previous information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child has a change in health and/or insurance coverage

Printed Name of PATIENT	Signature of PATIENT or PARENT/GUARDIAN	Date

PATIENT FINANCIAL POLICY

This office had adopted a financial policy that is outlined. If you have any questions regarding this policy, please discuss them with our office manager.

- Unless other arrangements have been made in advance by either you or your insurance carrier, full payment is due at the time of services are rendered.

Your Insurance

- We have made prior arrangements with many insurance carriers to accept assignment of benefits. This means that we will bill those plans for which we have an arrangement and will only require you to pay the authorized co-payment at the time of service. It is the policy of our office to collect this co-payment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have prior arrangement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer may send the payment directly to you. Consequently, the charges for your care and treatment may be due at the time of service.

In the event that your health plan determines a service to be not covered, you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

Minor Patients

- For all services rendered to minor patients, responsibility will fall to the adult accompanying the patient or the parent or guardian with custody for payment.

I hereby authorize Dr. Jonathan Goff to use other diagnostic aids to make a thorough diagnosis of my chiropractic needs. I have answered all questions concerning my medical health history to the best of my knowledge.

- I authorize the release of my medical records to secure payment of insurance benefits.
- I authorize my insurance company to assign benefits to Back and Body Chiropractic for payment of services rendered.
- I authorize the use of this signature on all insurance submissions.
- I have read the copy of the privacy policy information and will/have reviewed the information.

Please note that a cancellation fee will be charged unless notice is given 24 hours prior to a scheduled appointment.

A $25.00 fee will be charged for any returned check plus any recovery fees that may be incurred.

I have read and understand the Financial Policy, Signature Authorization, and Privacy Policy, and I agree to its terms and definitions. I also understand and agree that such terms may be amended from time to time by the practice.

Printed Name of PATIENT	Signature of PATIENT or PARENT/GUARDIAN	Date