

## The Center for Total Back Care Patient Registration Form

Date: \_\_\_\_\_

TELL US ABOUT YOU			
Name:	Preferred Name:	(Circle One) Male    Female	SSN#:
Address:			Date of Birth:
City:	State:	Zip:	Referral Name:
Home Phone:		Referred type: <input type="checkbox"/> Doctor <input type="checkbox"/> Internet <input type="checkbox"/> Friend <input type="checkbox"/> Other:	
Work Phone:		Primary Doctor:	
Cell Phone:		Employer:	
Email:		Type of work:	

EMERGENCY INFORMATION	
Person to Contact in Emergency:	Relation:
Address:	
City:	State:                      Zip:
Home Phone:	Cell Phone:

REASON FOR VISIT	
Visit is a result of (Check one) <input type="checkbox"/> Auto Accident <input type="checkbox"/> Work Injury <input type="checkbox"/> Trauma <input type="checkbox"/> Sports <input type="checkbox"/> Gradual Onset <input type="checkbox"/> Chronic Pain	
Please explain what happened:	Date Condition Began:
	Is this interfering with work, sleep, daily routine?    Yes    No
	If so, please explain:

Tell us about your past care		Health History	
Check all that apply:	Helpful?	Have you ever had any of the following diseases/medical conditions?	
<input type="checkbox"/> Physical Therapy	Y    N	<input type="checkbox"/> Frequent Neck Pain	<input type="checkbox"/> Cancer
<input type="checkbox"/> Surgery	Y    N	<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Epidural	Y    N	<input type="checkbox"/> Severe Frequent Headaches	<input type="checkbox"/> Anemia
<input type="checkbox"/> Injections	Y    N	<input type="checkbox"/> Fainting /Seizures /Epilepsy	<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Nerve Block	Y    N	<input type="checkbox"/> Arm /Leg Pain	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Bio Feedback	Y    N	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Chronic Care	Y    N	<input type="checkbox"/> Artificial Bones /Joints	<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> Supervised Exercise	Y    N	<input type="checkbox"/> Asthma / Emphysema	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Back School	Y    N	<input type="checkbox"/> Ulcers /Colitis	<input type="checkbox"/> Congenital Heart Defect
<input type="checkbox"/> Acupuncture	Y    N	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Mitral Valve Prolapse
<input type="checkbox"/> Chiropractic	Y    N	<input type="checkbox"/> Alcohol /Drug Abuse	<input type="checkbox"/> Artificial Valves
<input type="checkbox"/> Other: _____	Y    N	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> _____	Y    N	<input type="checkbox"/> HIV /AIDS	<input type="checkbox"/> High /Low Blood Pressure
<input type="checkbox"/> _____	Y    N	<input type="checkbox"/> Shingles	<input type="checkbox"/> Diabetes
<input type="checkbox"/> _____	Y    N	<input type="checkbox"/> Psychiatric Problems	<input type="checkbox"/> Tuberculosis

**\* Please fill out other side \***

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Are you taking any medications?    Yes    No                      If Yes, please list:	
Please list any other serious medical condition(s) you have ever had:	
Please list anything that you may be allergic to:	
List past serious accidents:	
Family health history: <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Other:	
Do you smoke?    Yes    No                      How Much?:                      How Long?:	
Do you wear? <input type="checkbox"/> Heel Lifts <input type="checkbox"/> Sole Lifts <input type="checkbox"/> Inner soles <input type="checkbox"/> Arch supports <input type="checkbox"/> Other:	
What is the age of your mattress?:                      Is it comfortable?:    Yes    No	
Do you sleep on your: <input type="checkbox"/> Back <input type="checkbox"/> Side <input type="checkbox"/> Stomach <input type="checkbox"/> At an Incline <input type="checkbox"/> Other:	
For Women:    Do you take birth control?    Yes    No                      If Yes, how long?:	
Are you pregnant?    Yes    No                      If Yes, how Long?:                      Are you nursing?:                      Yes    No	
Other conditions/complications?    Yes    No                      If Yes, Please list:	
<b>FINANCIAL RESPONSIBILITY</b>	
Person Responsible:	Insured's Name:
Address:	Insured's ID#:
City:                      State:                      Zip:	Insured's DOB:
Phone:	Group Policy #:
Relationship to Patient:	Insured's Employer:
Insurance Company:	Employers Phone:
<b>PLEASE READ AND SIGN</b>	
<p>We invite you to discuss with us any questions regarding our services and/or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.</p> <p>Our Policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. As a courtesy to you, we will usually bill your insurance for you, however, insurance is a contract between you and your insurance company and you are ultimately responsible for all fees incurred as a result of any treatment you receive in this office.</p> <p>If your account is <b>not paid within 90 days</b> of the date service, and no financial arrangements have been made, <b>a service fee of 25% of the outstanding balance will be added to your account</b> for collection agency fees, and any other expenses incurred collecting your account.</p> <p>If this was a result of a motor vehicle accident, your insurance may not cover specific treatments that may be beneficial in your case. We reserve the right to collect our usual and customary fees for services rendered during your treatment in this office.</p> <p>I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or collect on my account. I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered.</p> <p>I understand the above information, and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.</p>	
<p>Patient's Signature: _____                      Date: _____</p>	

**\* Please fill out other side \***