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:		Marital Status	Married Never Married Divorced Domestic Partner Widowed
Home Phone:		Referred source:	☐ Doctor ☐ Internet ☐ Friend ☐ Other:
Work Phone:		Referral Name:	
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) ☐ Auto Accident ☐ Work Injury ☐ Trauma ☐ Sports ☐ Gradual Onset ☐ Chronic Pain

Area of complaint:	Date Condition Began:
Please explain what happened:	Is this interfering with work, sleep, daily routine? Yes No
	If yes, please explain:

Tell us about your past care

Check all that apply:		Helpful?	
☐	Physical Therapy	Y	N
☐	Surgery	Y	N
☐	Epidural	Y	N
☐	Injections	Y	N
☐	Nerve Block	Y	N
☐	Bio Feedback	Y	N
☐	Chronic Care	Y	N
☐	Supervised Exercise	Y	N
☐	Back School	Y	N
☐	Acupuncture	Y	N
☐	Chiropractic	Y	N
☐	Other: _____	Y	N
☐		Y	N
☐		Y	N
☐		Y	N

Medical History

Have you ever had any of the following diseases/medical conditions?

☐	Frequent Neck Pain	☐	Cancer
☐	Lower Back Pain	☐	Chemotherapy
☐	Severe Frequent Headaches	☐	Anemia
☐	Fainting /Seizures /Epilepsy	☐	Difficulty Breathing
☐	Arm /Leg Pain	☐	Heart Attack
☐	Arthritis	☐	Stroke
☐	Artificial Bones /Joints	☐	Heart Surgery
☐	Asthma / Emphysema	☐	Heart Murmur
☐	Ulcers /Colitis	☐	Congenital Heart Defect
☐	Kidney Problems	☐	Mitral Valve Prolapse
☐	Alcohol /Drug Abuse	☐	Artificial Valves
☐	Hepatitis	☐	Rheumatic Fever
☐	HIV /AIDS	☐	High /Low Blood Pressure
☐	Shingles	☐	Diabetes
☐	Psychiatric Problems	☐	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: ☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Stroke ☐ Other:
Do you smoke? Yes No **How Much?:** **How Long?:**
Do you wear? ☐ Heel Lifts ☐ Sole Lifts ☐ Inner soles ☐ Arch supports ☐ Other:
What is the age of your mattress?: Is it comfortable?: **Yes No**
Do you sleep on your: ☐ Back ☐ Side ☐ Stomach ☐ At an Incline ☐ 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:**

FINANCIAL RESPONSIBILITY

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:**

PLEASE READ AND SIGN

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.

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.

If your account is **not paid within 90 days** of the date service, and no financial arrangements have been made, **a service fee of 25% of the outstanding balance will be added to your account** for collection agency fees, and any other expenses incurred collecting your account.

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.

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.

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.

Patient's Signature: _____ Date: _____

*** Please fill out other side ***